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ABSTRACT

This instructor's guide is for a Psychiatric Aide II course intended to provide Psychiatric Aids Is who have demonstrated expertise in giving basic nursing care to the mentally ill with more advanced nursing interventions and techniques. (It is assumed that all nursing care the aides provide is under the direction of a Registered Nurse.) Introductory materials include organizational structure of the course, bibliography, instructional analysis, and master list of unit lesson plans. The course consists of three units and 27 lessons. The lesson plan provided for each lesson includes some or all of the following components: scope of unit; objectives; supplementary teaching/learning items; informational assignment; references; introduction; outline of key points; interaction items; classroom, laboratory, shop, or other activities; and handout(s). Tests (with answer keys) include one for units I and II and two for unit III. Unit titles are The Psychiatric Aide II as a Member of the Treatment Team (7 lessons), The Individualized Treatment Planning Process (3 lessons), and Mental Health Nursing (17 lessons). Forms are appended for student evaluation of the course and instructor(s). (YLB)

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PSYCHIATRIC AIDE II

Instructor's Guide

Belinda K. Heimericks, R.N., B.S.N.

Produced by the Instructional Materials Laboratory
University of Missouri-Columbia
Columbia, Missouri

July 1982

IE-63-I

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FOREWORD

This publication is intended to be used as a training course for nursing service employees who have worked at least one year in a mental health facility and who have demonstrated superior skill and knowledge in providing basic nursing care to the mentally ill.

This course has been designed to provide the Psychiatric Aide II with the necessary knowledge to more comprehensively meet the nursing care needs of the mentally ill through the utilization of more advanced nursing interventions and techniques. It is assumed that this care is provided under the direction of the Registered Nurse.

Appreciation is expressed to an excellent committee and the many individuals who helped in the development of this publication. A special thanks is extended to Ruth Lewis, M.A., R.N., and Judy Sanders, M.S.N., R.N., for the leadership and guidance they have given throughout this endeavor, and to E. June Meyer for the information used from the Nurse Assistant in a Long-Term Care Facility.

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PSYCHIATRIC AIDE II

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ORGANIZATIONAL STRUCTURE

I. INTRODUCTION

The purpose of the Psychiatric Aide II Course is to provide Psychiatric Aide I's who have demonstrated expertise in giving basic nursing care to the mentally ill under the direction of the Registered Nurse an opportunity to further their knowledge and skills in mental health nursing as well as to provide an avenue for career advancement.

II. STATEMENT OF PHILOSOPHY

It is the right of every individual to receive optimum health care delivered by trained personnel. Federal and State Laws and Regulations are adopted to insure quality care to patients of mental health care facilities. The psychiatric aide acquires knowledge and skills through a prescribed educational program. The patient's welfare is the responsibility of the psychiatric aide as well as the other members of the interdisciplinary treatment team.

III. OBJECTIVES

Upon completion of this course, the Psychiatric Aide II will be able to:

A. Identify their role as an active member of the multidisciplinary team.

B. Articulate their legal and ethical responsibilities as a Psychiatric Aide II.

C. Communicate effectively with coworkers.

D. Develop therapeutic relationship with patients.

E. Observe, report and record in accordance with the individualized plan of care.

F. Demonstrate accountability for his/her assigned duties.

G. Model mentally healthy behavior.

H. Demonstrate advanced knowledge and technical skills in the care of the mentally ill patient.

I. Identify characteristics of the therapeutic milieu and it's importance to the patients individualized treatment.

J. Identify signs and symptoms of impending assaultive behavior and begin interventions based upon the patient's action.

IV. STUDENT QUALIFICATIONS

Capable of meeting employment criteria outlined by the Missouri Department of Mental Health and the Missouri Division of Personnel.

V. EDUCATIONAL PROGRAM

A. The basic program consists of a minimum of 62.5 hours of classroom-laboratory instruction. Evaluations include a minimum of three examinations over theory.

B. A minimum of 125 hours clinical training and practice will be given each participant under the supervision of a clinical instructor from the Nursing Education Department. The instructor shall provide documentation of completion of the clincial practice prior to the issuance of a certificate.

C. Testing:

Minimum of three written or oral tests throughout the course. An average score of 70% in each unit is required to successfully complete the course.

D. Curriculum Guides and References

1. The curriculum with lesson plans will be available after November 1, 1982, from: Instructional Materials Laboratory, Room 10, Industrial Education Building, University of Missouri-Columbia, Columbia, MO 65211. This includes an instructor and a student guide.

2. It is advisable that the instructor purchase the following reference books:

    a. "Abnormal Psychology," 3rd ed., by Gerald C. Davison and John M. Neale, from John Wiley & Sons, Inc., New York, NY, 1982.

    b. "Comprehensive Psychiatric Nursing" by Judith Haber, Anita M. Leach, Sylvia M. Schudy, and Barbara Flynn Sideleau, from McGraw-Hill Book Co., St. Louis, MO, 1978.

    c. "Manual of Psychiatric Nursing Care Plans" by Judith M. Schultz and Sheila L. Dark, from Little, Brown & Co., Boston, MA, 1982.

d. "Mental Health Nursing: A Bio-Psycho-Cultural Approach" by Elaine A. Pasquali, Eleanor G. Alesi, Helen M. Arnold, and Nancy DeBasio, from C. V. Mosby Co., St. Louis, MO, 1981.

E. Evaluations of the program will be requested from the participants and the mental health care facility employer(s).

F. A certificate of completion will be issued by the instructing facility. This certificate will enable the graduate to transfer to other mental health care facilities and receive an orientation to that facility without repeating the complete course.

VI. TRAINING FACILITIES

Health care facilities which have a classroom and practice laboratory with one or more bed units and equipment used in delivering health care outlined in the curriculum.

VII. FACULTY QUALIFICATIONS

Instructor

A. Three years experience as a professional nurse

B. One year of work experience in a mental health care facility within the past five years

C. Must be currently licensed in the State of Missouri as a Registered Professional Nurse

D. Instructors teaching in noneducational facilities shall be certifiable as vocational instructors. Upon Presentation of credentials (resume), a letter will be provided from the State Supervisor of Health Occupations Education, Career and Adult Education, Department of Elementary and Secondary Education, indicating the status of the instructor's qualifications.

Instructors teaching through public education centers shall hold valid vocational teaching certificates.

E. Employed by facility where experience is performed or a cooperating public education agency offering vocation education programs.

VIII. EXCEPTIONS

A. Reciprocity shall be granted persons from other states who can show documentation of successful completion of a similar state approved course.

B. Psychiatric aides working part time and who are employed by a placement agency must have completed the state approved course prior to functioning in a mental health care facility.

C. Allied health care personnel such as emergency medical technicians, medical laboratory technicians, surgical technicians, central supply technicians, dental auxiliaries, shall not be considered qualified for this health occupation and shall not be allowed to challenge the final examinations.

IX. CONTINUING IN-SERVICE EDUCATION

There will also be a number of procedures which a psychiatric aide could perform which will not be covered in the basic course but would be appropriate for continuing inservice education in the facility of employment.

SPECIAL NOTES TO THE INSTRUCTOR

(Curriculum Implementation)

1. May be conducted totally in the mental health facility or in cooperation with public education agencies offering vocational programs

2. The suggested time schedule on the Master List (gold pages) may be altered in order to meet the learning abilities of students.

3. Personal/Professional Competencies

    a. The student must receive a satisfactory score on 70% of the personal/professional competency items.

    b. A Personal/Professional Competency form shall be completed by each clinical instructor. The student must achieve a satisfactory score in each clinical area in order to pass the course.

4. The Red Cross Basic First Aid or Multimedia Course is to be taught as part of the Psychiatric Aide I course. Certification will be according to Red Cross guidelines.

5. The Red Cross or American Heart Association C.P.R. Course is to be part of this course. Certification will be according to the above certifying agencies' guidelines. C.P.R. and/or First Aid Certification will not be required for successful completion of the Psychiatric Aide II Course.

6. If a student has a handicap which prevents him/her from performing a procedure, follow your facility's guidelines concerning this matter.

7. The unit examinations may be rewritten and/or revised to meet the needs of the individual facilities.

8. A minimum score of 70% is required for passing unit examinations.

9. If a student fails an examination, he/she has the opportunity to retake the examination one time.

10. The final record is the competency form which is to be kept on file for inspection/transcript purposes.

11. Challenge examinations may be conducted at the same time that students pass three examinations given during the course with a score of 70% or above on each examination.

12. Activities and Handouts

    a. Activities are suggested and may be revised or omitted as deemed necessary by the individual facilities.

    b. Activities and/or handouts can be presented in the lesson where the instructor believes they are most appropriate. An appropriate place has been noted on some lessons where it says "See Activity # " and/or "See Handout # ."

13. Suggested ideas for evaluating clinical performance

    a. Process recordings

    b. Daily logs

    c. Case study

    d. Participation in a support group as a group facilitator

14. The following lessons are to be taught/reviewed in the Psychiatric Aide II Course but are not included in the Psychiatric Aide II Curriculum Guide. They can be found in the Psychiatric Aide I Curriculum Guide.

    a. The Aide's Role During an Emergency/Disaster

    b. Maintenance of a Safe Environment

    c. Wash Hands

AUDIO-VISUAL RESOURCES

Film and Literature Library
Missouri Division of Health
P.O. Box 570
Broadway State Office Building
Jefferson City, MO 65102

Trainex Coporation
P.O. Box 116
Garden Grove, CA 92642
800-854-2485 (Toll Free)

Concept Media
5024 Lankerskim Blvd.
N. Hollywood, CA 91601
714-833-3347

Cornet Films
St. Louis City Library
1301 Olive St.
St. Louis, MO 63102

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Lakein, Alan. How to Get Control of Your Time and Your Life. New York: Signet, 1973.

Lewis, LuVerne Wolff. Fundamental Skills in Patient Care. 2nd ed. Philadelphia: J. B. Lippincott Co., 1980.

Miller, J. R. and Janosik, E. Family Focused Care. St. Louis: McGraw-Hill Book Co., 1980.

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PSYCHIATRIC AIDE II INSTRUCTIONAL ANALYSIS

DEMONSTRATION	INFORMATION

THE PSYCHIATRIC AIDE II AS A MEMBER OF THE TREATMENT TEAM

1. Becoming a Psychiatric Aide II
2. Ethical and Legal Responsibilities
3. Overview of Communication Skills
4. The Team Concept
5. Planning and Organizing Your Work
6. Communicating Effectively With Coworkers
7. Promoting a Therapeutic Work Environment

THE INDIVIDUALIZED TREATMENT PLANNING PROCESS

8. Understanding the Development of an Individualized Plan of Care
9. Providing Nursing Care Based on the Individualized Plan of Care
10. Recording Observations in Relation to the Individualized Plan of Care

MENTAL HEALTH NURSING

11. Understanding Mental Health
12. Understanding How Culture Affects Behavior
13. The Patients and Their Families
14. Current Therapies Used in Treating the Mentally Ill
15. Psychotropic Medication Therapy

16. The Psychiatric Aide II - Responsibility in Support Groups

17. Therapeutic Milieu

18. Developing a Therapeutic Aide - Patient Relationship

19. The Patient who copes by Withdrawing From Reality

20. The Patient who copes by Turning Aggression Inward

21. The Patient who Becomes Elated

22. The Patient who must cope with Impaired Brain Function

23. The Patient who copes by Becoming Socially Deviant

24. The Patient who copes by Using Drugs and Alcohol

25. Prevention of Assaultive Behavior

26. The Patient who is Suicidal

27. The Mentally Ill Patient who has Seizures

MASTER LIST - UNIT LESSON PLANS

COURSE TITLE: PSYCHIATRIC AIDE II

Lesson Plan #	Date	I.T. #	D. #	Lesson Title	Time Allotted
UNIT I: THE PSYCHIATRIC AIDE II AS A MEMBER OF THE TREATMENT TEAM					
L.P. 1, p. 1		I-1		Becoming A Psychiatric Aide II	120'*
L.P. 2, p. 15		I-2		Ethical And Legal Responsibilities	60'
L.P. 3, p. 31		I-3		Overview Of Communication Skills	120'
L.P. 4, p. 59		I-4		The Team Concept	30'
L.P. 5, p. 73		I-5		Planning And Organizing Your Work	30'
L.P. 6, p. 79		I-6		Communicating Effectively With Co-workers	30'
L.P. 7, p. 87		I-7		Promoting A Therapeutic Work Environment	30'
				***The Aide's Role During an Emergency/ Disaster	120'
				***Maintenance Of A Safe Environment	60'
				***Wash Hands	30'
UNIT II: THE INDIVIDUALIZED TREATMENT PLANNING PROCESS					
L.P. 8, p. 95		II-1		Understanding The Development Of An Individualized Plan Of Care	60'
L.P. 9, p. 105		II-2		Providing Nursing Care Based On The Individualized Plan Of Care	60'
L.P.10, p. 111		II-3		Recording Observations In Relation To The Individualized Plan Of Care	60'
Unit I & II Test					60'

*' Symbolizes minutes

***These lessons are not included in the Psychiatric Aide II Instructor's Manual, but are taught as part of the Psychiatric Aide II Course.

Lesson Plan #	Date	I.T. #	D. #	Lesson Title	Time Allotted
UNIT III: MENTAL HEALTH NURSING					
L.P.11, p. 125		III-1		Understanding Mental Health	120'
L.P.12, p. 143		III-2		Understanding How Culture Affects Behavior	60'
L.P.13, p. 151		III-3		The Patients And Their Families	60'
L.P.14, p. 157		III-4		Current Therapies Used In Treating The Mentally Ill	60'
L.P.15, p. 169		III-5		Psychotropic Medication Therapy	240'
L.P.16, p. 193		III-6		The Psychiatric Aide II - Responsibility In Support Groups	120'
L.P.17, p. 213		III-7		Therapeutic Milieu	60'
L.P.18, p. 223		III-8		Developing A Therapeutic Aide - Patient Relationship	60'
Unit III Test I					60'
L.P.19, p. 239		III-9		The Patient Who Copes By Withdrawing From Reality	120'
L.P.20, p. 249		III-10		The Patient Who Copes By Turning Aggression Inward	120'
L.P.21, p. 261		III-11		The Patient Who Becomes Elated	120'
L.P.22, p. 269		III-12		The Patient Who Must Cope With Impaired Brain Function	120'
L.P.23, p. 285		III-13		The Patient Who Copes By Becoming Socially Deviant	120'
L.P.24, p. 293		III-14		The Patient Who Copes By Using Drugs And Alcohol	120'
L.P.25, p. 311		III-15		Prevention Of Assaultive Behavior	120'
L.P.26, p. 325		III-16		The Patient Who Is Suicidal	120'
L.P.27, p. 333		III-17		The Mentally Ill Patient Who Has Seizures	60'
				***Cardio-Pulmonary Resuscitation	480'
				***First Aid	480'
Unit III Test II					60'

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*' symbolizes minutes.

**Oral tests may be given if student scores below 70 on written.

***These lessons are not included in the Psychiatric Aide II Instructor's Manual, but are taught as part of the Psychiatric Aide II Course.

Total Hours Classroom Instruction = 62.5 Hours
Total Clinical Hours = 125 Hours

LESSON PLAN: 1

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT I : THE PSYCHIATRIC AIDE II AS A MEMBER OF THE TREATMENT TEAM

SCOPE OF UNIT:

This unit presents an overview of the Psychiatric Aide II Course and reviews key lessons and information taught in the Psychiatric Aide I Course that are considered essential knowledge necessary for the successful completion of this course. It also provides the student with an understanding of the team concept along with techniques that will assist in better utilization of time, communicating more effectively with the coworkers, and in promoting a better work environment.

INFORMATION TOPIC: I-3 OR DEMONSTRATION: ______

BECOMING A PSYCHIATRIC AIDE II
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT SHOULD BE ABLE TO:

1. Recall nine objectives of the course.
2. Identify five methods of evaluating classroom activities.
3. Recall and practice 15 habits that improve study.
4. Recall six qualities of a psychiatric aide.
5. Identify four reasons why a person should assess his/her current skills.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Sample evaluation tools
2. Selected references (to include dictionaries)
3. Handout #1: Job Description of a Psychiatric Aide II

INFORMATIONAL ASSIGNMENT: (Student)

Heimericks, Belinda. Psychiatric Aide I. Columbia, MO: Instructional Materials Laboratory, University of Missouri-Columbia, 1982, pp. 11-12.

REFERENCES: (Instructor's Additional Information)

INTRODUCTION:

This course is designed for the psychiatric aide who has been promoted to a PA II and has been employed in a mental health care facility for at least one year. Our lesson today will include an overview of the course objectives, course requirements, the course management, study habits, and essential qualities of the psychiatric aide in a mental health care facility. The lesson will conclude with an assessment of your current level of skills.

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LESSON PLAN: 1

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT I : THE PSYCHIATRIC AIDE II AS A MEMBER OF THE TREATMENT TEAM

INFORMATION TOPIC: I-1

OUTLINE: (Key Points)

I. Goals and Objectives

A. Identify the Psychiatric Aide II role as an active member of the multidisciplinary team.

B. Articulate the legal and ethical responsibilities of a Psychiatric Aide II.

C. Communicate effectively with coworkers.

D. Develop therapeutic relationship with patients.

E. Observe, report, and record in accordance with the individualized plan of care.

F. Demonstrate accountability for his/her assigned duties.

G. Model mentally healthy behavior.

H. Demonstrate advanced knowledge and technical skills in the care of the mentally ill patient.

I. Identify characteristics of the therapeutic milieu and its importance to the patient's individualized treatment.

J. Identify signs and symptoms of impending assaultive behavior and begin interventions based upon the patient's action.

K. Recognize and report major adverse effects of psychotrophic medications.

L. Maintain a safe and clean environment.

M. Recognize the need for and participate in in-service educations.

II. Course Requirements

A. Qualifications of students - Capable of meeting employment criteria outlined by the Department of Mental Health and the Division of Personnel regulations

B. Educational program

1. The basic program consists of a minimum of 62.5 hours of classroom-laboratory instruction. Evaluations include examinations over each theory lesson. Examiners shall be the instructor(s) who taught the basic course.

2. A minimum of 125 hours on-the-job clinical practice will be given each participant under the supervision of a clinical instructor from the Nursing Education Department or registered nurse. (The instructor shall provide documentation of completion of the clinical practice prior to the issuance of a certificate.)

3. Evaluation of the program will be requested from the participants and the health care facility employers.

C. Classroom strategies

1. Overview

2. Use of student guide (includes most handouts)

3. Use of references

    a. Textbooks

    b. Periodicals

    c. Pamphlets

4. Audio-visual materials

5. Evaluation

    a. Worksheets

    b. Written tests over each theory lesson prior to the final with a minimum passing score of 70% in each unit. Quizes may be given as necessary.

    c. Classroom discussion and participation in activities

    d. Clinical performance includes (but is not limited to)

        1) Participating as a support group facilitator.

        2) Developing therapeutic relationships with patients.

        3) Demonstrating accountability for assigned duties.

    e. Processing recordings and/or daily log or journal of clinical activities.

III. Review of Study Habits

- A. Environment
    - 1. Quiet
    - 2. No TV or radio
- B. Preview material.
    - 1. Read material quickly.
    - 2. Use topic headings of key sentences.
    - 3. Ask yourself what each paragraph contains.
- C. Read each paragraph.
    - 1. Remember, reading words is a waste of time.
    - 2. State its content or ideas in your own words.
    - 3. Underline important words, sentences, or phrases.
    - 4. State topic out loud.
- D. Test yourself. Construct your own test questions.
- E. Time for study
    - 1. Study as soon as possible after class.
    - 2. Fill in notes or reorganize notes.
    - 3. Do assignments as soon as possible after they have been given.
- F. Reference materials
    - 1. Use library frequently.
    - 2. Look up new words in the dictionary.
- G. Taking a test
    - 1. Read the questions quickly but thoroughly. Read each word of the question and all choices.
    - 2. Select the answer you believe correct - usually your first thought is correct.

IV. Review of the Essential Qualities of the Psychiatric Aide

- A. As a PA II, it is assumed you have these essential qualities:

1. Expected to model mentally healthy behavior
2. Patients and HA I's and PA I's look up to you

B. Personal Hygiene

1. Bathe daily.
2. Use deodorants.
3. Prevent bad breath by brushing teeth.
4. Fingernails
    a. Short, trimmed
    b. Neatly shaped
    c. Cleaned
5. Hair
    a. Neat and clean
    b. Simple style
    c. Keep out of face (Long hair must be pinned up so loose hairs do not contaminate when performing certain nursing procedures.)

C. Personal health

1. Eat well-balanced diet.
2. Acquire adequate sleep and relaxation.
3. Cope with stress (inner pressures).
4. Practice good body posture.
5. Never take alcohol or drugs before going on duty.
6. Prevent disease.
    a. Handwashing
    b. Immunization
    c. Health maintenance program

D. Clothing and accessories

1. Appropriate clothing for duty will be determined by the facility and unit where you are assigned.

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2. Change lingerie and underclothing daily.
3. Undergarments should provide good support.
4. Check policy of facility regarding jewelry.
    a. Wedding ring only
    b. Small, inconspicuous earrings
5. Stockings should be changed daily.
6. Shoes should be comfortable and give support.
    a. Clean and polish daily if white.
    b. Wash shoestrings.
    c. Color of shoes according to facility policy
7. Make-up
    a. Use in moderation.
    b. No perfume which nauseates ill persons

E. Personality (totality of an individual's behavioral and emothional tendencies)
1. Charm (how to please others)
2. Poise (even tempered, composed)
3. Dignity (self-control)
4. Attitudes (feelings about people, places, and things)
    a. Positive
    b. Negative
5. Habits (repetition of behavior - acquired)

F. Conduct
1. Confidentiality
2. Professional behavior
3. Gossip
4. Courtesy

G. Dependability
1. Report to work on time.

2. Use facility procedure for absenteeism.

3. Work habits

4. Personal habits

V. Assessing Your Current Skills and Abilities

A. Enables you to:

1. Function at your maximum potential.
2. Capitalize on your strengths.
3. Improve less developed skills.
4. See the progress you have made toward the accomplishment of goals.

B. Ask yourself the following questions in order to assess your current level of skills.

1. How much better am I at my work today than I was one year ago?
2. How much more knowledge do I have today than I did one year ago?
3. How much of that knowledge do I use daily in my work?
4. If I am not using that knowledge, why not?
5. What have I done in the past year to improve my job skills?
6. What do I like most about my job?
7. What do I like least about my job?
8. What do I do best in my job?
9. What tasks are hardest for me?
10. With what kind of patient behaviors am I most successful working? Why?
11. With what kind of patient behaviors do I have the most difficulty working? Why?
12. When did I last discuss my skills with my supervisor?
13. What was said and who said it?
14. Did I tell my supervisor what I believe are my strengths and where I need improvements?

15. Why is it important to share this information with my supervisor?

16. What are my personal/professional goals for the coming year?

17. What are my beliefs and feelings toward mental illness and people suffering from mental illness?

18. How have these beliefs and feelings changed since coming to work in a psychiatric facility?

19. How can I improve my skills?

VI. Summary and Conclusion

A. Goals and objectives

B. Course requirements

C. Study habits

D. Essential qualities of the psychiatric aide

E. Assessing your current skills

In this lesson we have provided an overview of the course and have reviewed study habits that will assist you in your learning. This lesson has provided information for thought about your current skills and needed areas of improvement. This knowledge will assist you in identifying your personal/professional goals for the course.

LESSON PLAN: 1

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT I : THE PSYCHIATRIC AIDE II AS A MEMBER OF THE TREATMENT TEAM

INFORMATION TOPIC: I-1

INTERACTION ITEMS:

1. Let us recap the objectives of this course. Who can name one?
2. List the student qualifications to become a Psychiatric Aide.
3. What are some of the ways you will be graded (evaluated) in this course?
4. What would you include in your plan to strengthen your study skills?
5. What are some of the job duties of the Psychiatric Aide II?
6. Why is it important to know what your skills, strengths and weaknesses are?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

1. Review with the class how to use a dictionary and other reference books such as P.D.R.
2. Examine samples of work sheets and written and performance tests.
3. Outline plan to develop study skills.
4. Have students write their personal/professional goals for this class.

Handout #1

JOB DESCRIPTION OF A PSYCHIATRIC AIDE II

I. Position Title: Psychiatric Aide II

II. Definition: The Psychiatric Aide II performs nonprofessional psychiatric nursing techniques which include utilizing therapeutic communication skills, maintaining a therapeutic milieu, demonstrating a knowledge of the action and side effects of psychotropic medications, facilitating reality orientation and remotivation groups, modeling socialization skills for patients, and participating as a member of the treatment team. The Psychiatric Aide II performs specific physical procedures and assigned tasks for the smooth functioning of the patient care unit.

III. Qualifications

A. Passes Psychiatric Aide II State Merit Exam with a score of 70 or above.

B. Attends and successfully completes the Psychiatric Aide II Course according to the criteria established by the State of Missouri and the Mental Health Facility's Department of Nursing Education.

C. Passes the probationary period of employment with a service report score of 70 or above.

D. Maintains annual service report scores of 70 or above.

E. Successfully completes required continuing education programs.

F. Performs in accordance with rules and regulations of the Department of Mental Health, your employing Mental Health Facility and the Department of Nursing as outlined in the Employee Handbook, your employing Mental Health Facility Policy and Procedure Handbook and the Department of Nursing Policy and Procedure Manual.

IV. Functions Performed Under the Direction of the Registered Nurse

A. Observes, reports, and records information about the patient in reference to the plan of care.

B. Carries out nursing interventions based on the patient's behavior and the plan of care

C. Supports and protects patients by respecting their rights.

D. Assists the Registered Nurse in preventing and managing assaultive behavior.

E. Asists the Registered Nurse in providing nursing care to the patient in seclusion and/or restraints.

F. Monitors suicidal and homicidal patients.

G. Develops therapeutic relationships with patients.

H. Participates in patient support groups.

I. Recognizes and reports to the Reg. Nurse the expected and major adverse effects of psychotropic medications.

J. Assists in maintaining a therapeutic milieu on the unit.

K. Assists in managing the enviroment for cleanliness and safety.

L. Assists in the orientation of the HA I's.

M. Participates as an active member of the treatment team.

N. Assumes accountability for his/her assigned duties.

O. Models mentally healthy behavior.

P. Participates in self-development through inservice education programs.

Q. Performs emergency procedures taught in the Psychiatric Aide II Course during Code Blue, ward evacuation, psychiatric emergencies, etc.

R. Performs in-patient admission procedures such as;

   1. Accompanying patients to ward from Admissions Office.

   2. Familiarizing patients with ward environment and policies.

   3. Completing nursing admission forms for patient's chart according to the procedure delineated in the Nursing Policy and Procedure Manual.

S. Performs other duties as assigned by the nurse in charge of his/her designee.

LESSON PLAN: 2

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT I : THE PSYCHIATRIC AIDE II AS A MEMBER OF THE TREATMENT TEAM

SCOPE OF UNIT:

This unit presents an overview of the Psychiatric Aide II Course and reviews key lessons and information taught in the Psychiatric Aide I Course that are considered essential knowledge necessary for the successful completion of this course. It also provides the student with an understanding of the team concept along with techniques that will assist in better utilization of time, communicating more effectively with the coworkers, and in promoting a better work environment.

INFORMATION TOPIC: I-2 OR DEMONSTRATION: ______

ETHICAL AND LEGAL RESPONSIBILITIES
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT SHOULD BE ABLE TO:

1. Recognize medical and legal problems which represent assault, battery, false imprisonment, invasion of privacy, privileged communication and consent.
2. Identify six patient's rights.
3. Identify channel for reporting abuse and neglect to proper authorities.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Handout #1: Health Care Personnel - The Law and Ethics
2. Handout #2: Department Operating Regulations

    DOR 2.005: List of Client Rights

    DOR 2.010: Notification Requirements

    DOR 2.205: Abuse and Neglect Definitions, Investigation Procedures and Penalties

INFORMATIONAL ASSIGNMENT:

Handout #1: Health Care Personnel - The Law and Ethics

Handout #2: Patient's Rights

REFERENCES: (Instructor's Additional Information)

Wormsley, Ann, and Dolecki, Yolanda. Medication Technician. Columbia, MO: Instructional Materials Laboratory, University of Missouri-Columbia, 1978. pp. 9-19.

Handout #1: Health Care Personnel - The Law and Ethics

Handout #2: Department Operating Regulations

DOR 2.005: List of Client Rights

DOR 2.010: Notification Requirements

DOR 2.205: Abuse and Neglect Definitions, Investigation Procedures and Penalties

(NOTE: Please bring and discuss any additional current information regarding this subject matter.)

INTRODUCTION:

In this lesson we will discuss the ethical and legal responsibilities you should be aware of as psychiatric aide. To accomplish this, we will cite and/or role play common medical/legal problems; see how they relate to patient's rights; and learn the appropriate reporting process for dealing with grievances at your mental health care facility.

LESSON PLAN: 2

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT I : THE PSYCHIATRIC AIDE II AS A MEMBER OF THE TREATMENT TEAM

INFORMATION TOPIC: I-2

OUTLINE: (Key Points)

I. Medical/legal Problems (See Handout #1)
   A. Assault
   B. Battery
   C. Consent
   D. Duty of care
   E. Ethics
   F. False imprisonment
   G. Invasion of privacy
   H. Libel
   I. Malpractice
   J. Negligence
   K. Privileged communication
   L. Slander
   M. Breach
   N. Custom
   O. Conduct
   P. Ideal
   Q. Unethical
   R. Value system

II. Patient's Rights (See Handout #2)
   A. Federal
   B. State

III. Abuse and/or Neglect in Reporting

    A. Information reported

    B. Time limitation

    C. Confidentiality

    D. Investigation procedure

    E. Retaliation procedure

IV. Grievance Procedure for Facility

    A. Written procedure

    B. Complaint designee

    C. Document receipt, resolution, referral

V. Summary and Conclusion

    A. Medical/legal problems

    B. Patient's rights

    C. Abuse and/or neglect reporting

    D. Grievance procedure

In today's lesson, we have discussed the ethical and legal responsibilities of the psychiatric aide.

LESSON PLAN: 2

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT I : THE PSYCHIATRIC AIDE II AS A MEMBER OF THE TREATMENT TEAM

INFORMATION TOPIC: I-2

INTERACTION ITEMS: (Review Items)

1. What are other examples of medical/legal problems?
2. What are other examples of patient's rights?
3. How do psychiatric aides report abuse and/or neglect?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

1. Describe the complaint procedure of the facility in which you work.
2. Role play some situations which involve legal/ethical conduct.
   a. You have just witnessed a co-worker slap a patient who is resisting her efforts to get him to bed.
   b. One of your patients is making repeated attempts to go out-of-doors. In order to keep him/her safe while you give care to another, you tie him/her to a chair.
3. Role play some situations that involve a patient's rights.
   a. A visitor has just given a patient a twenty dollar bill. You know this confused person cannot manage it safely.
   b. A husband is visiting his wife who is a patient. The door to the room is closed and you need to deliver fresh water.

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HEALTH CARE PERSONNEL - THE LAW AND ETHICS

As an employee in the health care occupations, it is important for you to be aware of your legal and ethical responsibilities to prevent medical/legal problems.

When you serve patients in any way, or have access to their records, you are expected to maintain their confidence and trust. Any violation of the patient's trust and confidence may be defined as an illegal or immoral act.

There are certain laws which protect patients when entering the hospital or other health care facilities. The patient voluntarily signs an admission agreement giving his or her consent for treatment and care. Special consent forms are again required for special procedures. Always remember to check the chart for these forms and make sure they are signed when required.

Some possible situations for legal problems might be:

1. Restraining a patient: Are the restraints for the protection of the patient or the personnel? Must have a Dr.'s order.
2. Assault (threat to harm): Telling a patient, "If you don't be quiet, I'll tie your hands down."
3. Gossiping about patients may be defined as "defamation of character" or defamation by slander."
4. A written entry in a chart such as "the patient was a cross old crackpot today" could be defined as written defamation and "libel."
5. Personal information about patient comes under the classification of "privileged information."
6. In the long-term care facility, a surveyor may want to look at a patient's skin. Without the patient's consent or proper screening, this would be "invasion of privacy."

As a health care worker, you must be familiar with certain legal and ethical terms. The following list of terms will assist you in understanding your responsibility.

1. Assault: Threat or attempt to injure another in an illegal manner.
2. Battery: Unlawful touching of another person without his or her consent, with or without resultant injury.

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3. Consent: Permission granted voluntarily by a person in his or her right mind
4. Duty of care: The obligation under law for a health care worker to perform services for a patient which meet the common standards of practice expected in his or her community for a comparable worker
5. Ethics: The discipline dealing with what is good and bad and what is moral duty and obligation
6. False imprisonment: Holding or detaining a person against his or her will or without a physician's orders
7. Invasion of privacy: A civil wrong that unlawfully makes public knowledge of any private or personal information without the consent of the wronged person
8. Libel: A civil wrong; to communicate in writing defamatory matter about an individual or group to a third party
9. Malpractice: Professional care that has led to injury due to faulty practice or neglect
10. Negligence: Failure to perform in a reasonably prudent manner or by acceptable health care practices
11. Privileged communication: Any personal or private information which is relevent to a patient's care, given by the patient to medical personnel
12. Slander: Spoken statement of false charges or misrepresentations which defame or damage another's reputation
13. Breach: Breaking of a law or of any obligation or contract
14. Custom: Long-established practice; an accepted behavior
15. Conduct: One's actions in general; behavior
16. Ideal: A standard of perfection or excellence
17. Unethical: Not ethical; not representative of ideal behavior
18. Value system: Behavior: pattern of conduct or ideas that are accepted as worthwhile or meaningful

Legal documents are documents which are accepted in the courts of law as evidence of truth, e.g., patient's chart is a legal record and can come under scrutiny of a legal person. The "signed consent" also is a legal record. A will is a legal document, for it must be signed in ink and signed voluntarily; and a patient must be in sound mind with the signing witnessed by at least two persons over 21.

You can prevent legal and ethical problems from developing in your care of patients by observing the following rules:

1. Remember that the patient is your responsibility.
2. Observe the patient's rights and avoid violation of them.
3. Prepare all paper work correctly.
4. Know your lines of authority. Do only those things which you have been trained and supervised to do.
5. Find out about liability coverage.

Handout #2

Department Operating Regulation Number
DOR 2.005

Chapter	Subchapter	Effective Date	Number of Pages	Page Number
Client Rights	Rights of Clients	9/1/81	2	1

Subject	Authority	History
List of Client Rights	§630.050 RSMo	NEW

PURPOSE: Prescribes the statutory rights for clients.
APPLICATION: Applies to residential facilities, day programs and specialized services operated by the department.

(1) The following are client rights which may be limited only if the head of the facility determines that they are inconsistent with the client's therapeutic care, treatment, habilitation, or rehabilitation. (The limitations and the reasons for the limitations must be documented in the person's clinical record):

(A) To wear own clothes and to keep and use own personal possessions;

(B) To keep and be allowed to spend a reasonable sum of own money for canteen expenses and small purchases;

(C) To communicate by sealed mail or otherwise with persons, including agencies, inside or outside the facilities;

(D) To receive visitors of own choosing at reasonable times;

(E) To have reasonable access to a telephone, both to make and receive confidential calls;

(F) To have access to mental and medical records;

(G) To have opportunities to have physical exercise and outdoor recreation;

(H) To have reasonable, prompt access to current newspapers, magazines, and radio and television programs.

(2) The following client rights may not be limited:

(A) To receive visits from own attorney, physician or clergyman in private and at reasonable times;

(B) To communicate by sealed mail with the department, own legal counsel and with court, if any, which has jurisdiction over the person;

(C) To humane care and treatment;

(D) To the extent that facilities, equipment and personnel are available to medical care and treatment in accordance with the highest standards accepted in medical practice;

(E) To safe and sanitary housing;

(F) To not participate in non-therapeutic labor;

(G) To attend or not attend religious services;

(H) To receive prompt evaluation and care, treatment, habilitation or rehabilitation about which he is informed insofar as the client is capable of understanding;

(I) To be treated with dignity as a human being;

			Department Operating Regulation Number DOR 2.005
Subject List of Client Rights	Effective Date 9/1/81	Number of Pages 2	Page Number 2

(J) To not be the subject of experimental research without prior written and informed consent, except that no involuntary patient shall be subject to experimental research;

(K) To have access to consultation with a private physician at own expense;

(L) To be evaluated, treated, habilitated or rehabilitated in the least restrictive environment;

(M) To not be subject to any hazardous treatment or surgical procedures without consent unless such treatment or procedures are ordered by a court of competent jurisdiction;

(N) In case of hazardous treatment or irreversible surgical procedure, to have, upon request, an impartial review prior to implementation, except in case of emergency procedures required for preservation of person's life;

(O) To a nourishing, well-balanced and varied diet;

(P) To be free from verbal and physical abuse.

(3) Each client has the right to be free from physical or chemical restraint, isolation or seclusion unless it is determined by the head of the facility or the attending licensed physician to be necessary to protect the client or others.

(4) Information and records compiled, obtained, prepared or maintained by the facility in the course of providing services to clients are confidential, as provided by law.

(5) Each client has a right to an impartial review of alleged violations of rights assured under this regulation and state statute under the provisions of department operating regulations.

(6) No client shall be presumed to be incompetent, to forfeit any legal right, responsibility or obligation or suffer any legal disability as a citizen unless prescribed by law, as a consequence of receiving evaluation,care, treatment, habilitation or rehabilitation for mental disorder, mental illness, mental retardation, developmental disability, alcohol problem or drug problem.

(7) No department facility, day program or specialized service operated, funded or licensed by the department shall deny admission or other services to any person because of race, sex, creed, marital status, national origin, handicap or age.

Handout #2
(cont.)

				Department Operating Regulation Number DOR 2.010
Chapter Client Rights	Subchapter Rights of Clients	Effective Date 9/1/81	Number of Pages 1	Page Number 1

Subject Notification Requirements	Authority §630.050 RSMo	History NEW

PURPOSE: Prescribes the manner of notifying clients of their rights assured them under Chapter 630 RSMo.
APPLICATION: Applies to residential facilities, day programs, and specialized services operated by the department.

(1) As used in this operating regulation, unless the context clearly requires otherwise, the term "facility" shall mean a mental health facility, mental retardation facility, or regional center operated by the department including day programs operated by the department which are not a part of the facility or regional center.

(2) Each facility shall prominently post a list of client rights (DMH Forms 8125, 8126, 8127) in residential and activity areas in the facility, such as areas where clients sleep, have meals, engage in activities or receive evaluations, treatment, habilitation or rehabilitation or are admitted and receive visitors.

(3) At the time of admissions or whenever services are provided, each facility shall give each client a brochure that sets forth in plain language the following:
(A) A description of the facility, services and costs;
(B) Information as to how to seek conditional release or discharge;
(C) Statement of rights assured by Chapter 630 RSMo or the department in its rules and regulations;
(D) A description of the grievance procedure of alleged violations of rights of clients.

(4) If facility personnel do not believe a client can read the brochure with understanding, the facility personnel shall explain it to the client and document in the client's file that the explanation was given.

Handout #2
(cont.)

Department Operating Regulation Number
DOR 2.205

Chapter	Subchapter	Effective Date	Number of Pages	Page Number
Client Rights	Investigation Procedures	9/1/81	4	1

Subject	Authority	History
Abuse and Neglect Definitions, Investigation Procedures and Penalties	§630.050, RSMo	NEW

PURPOSE: Prescribes definitions and procedures for investigating and processing complaints of client abuse and neglect.
APPLICATION: Applies to residential facilities, day programs or specialized services operated by the department.

(1) As used in this operating regulation, unless the context clearly requires otherwise, the following terms shall mean:

(A) "Class I Neglect," failure of an employee to provide reasonable and necessary services to maintain the physical and mental health of any client when such failure presents either imminent danger to health, safety or welfare, or a substantial probability that death or physical injury would result.

(B) "Class II Neglect," failure of an employee to provide reasonable and necessary services to a client according to the treatment, habilitation or rehabilitation plan, if feasible, or according to acceptable standards of care.

(C) "Complaint," allegation that physical abuse, sexual abuse, verbal abuse, class I neglect, class II neglect has occurred.

(D) "Facility," mental health facility, mental retardation facility or regional center operated by the department, including day programs operated by the department which are not part of a facility or regional center.

(E) "Physical Abuse,"

(1) purposefully beating, striking, wounding, injuring any client, or

(2) in any manner whatsoever, mistreating or maltreating a client in a brutal or inhumane manner.

Physical abuse includes handling a client with any more force than is reasonably or apparently necessary for a client's proper control, treatment or management.

(F) "Sexual Abuse," any touching directly or through clothing of the genital, anus or breasts of a client for sexual purposes. Sexual purpose means for the arousing or gratifying of anyone's sexual desires. This definition includes the employee touching a client and the employee causing the client to touch the employee. It includes fondling through clothes. Also included are aiding or abetting sexual abuse between clients or failing to exercise duty to stop or prevent sexual abuse between clients.

(G) "Verbal Abuse," referring to a client in the client's presence with profanity or in a demeaning, undignified or derogatory manner.

			Department Operating Regulation Number DOR 2.205
Subject Abuse and Neglect Definitions, Investigation Procedures and Penalties	Effective Date 9/1/81	Number of Pages 4	Page Number 2

(2) If an incident of physical abuse, sexual abuse, or class I neglect occurs or is suspected to have occurred to a minor, then the head of the facility shall immediately report the incident to the Division of Family Services, either on the toll-free hotline (800-392-3738) or on the tie-line at 3448 in Jefferson City. Employees shall cooperate in the investigation by the Division of Family Services.

(3) Complaints shall be filed with the head of the facility as follows:

(A) Any person other than a department employee may either complete the department complaint form (DMH Form 8108) and give it to the person in charge of the ward, unit or facility or report the complaint to the person designated in charge of the ward, unit, or facility to be put on the department form;

(B) A department employee who has reasonable cause to believe, including employees receiving complaints under subsection "A" of this section, that a client of a facility has been subjected to physical abuse, sexual abuse, class I neglect or class II neglect, shall immediately complete and file with the head of the facility on the department complaint form. Failure to so report is cause for disciplinary action or criminal prosecution or both.

(C) The department complaint form (DMH Form 8108) shall contain the name of the client alleged to have been abused or neglected; the nature of the abuse or neglect; the name of the complainant; date of the complaint; when and where the alleged abuse and neglect took place; names of witnesses; and other information to aid the investigation. Within five (5) working days after a complaint is received under this section, the person making the complaint shall be notified in writing of its receipt and the initiation of the investigation.

(4) The complaint form shall immediately be given to the person in charge of the facility during the particular shift when the complaint is received. The complainant may also send a copy of the complaint directly to the client affairs monitor. The person in charge of the facility in the absence of the head of the facility shall notify the head of the facility of the complaint. The person in charge shall immediately (no later than 24 hours after receiving the complaint) initiate an investigation by having written or tape recorded or both, statements taken from witnesses and others involved. If the suspected physical abuse, sexual abuse or class I neglect result in physical injury, the head of the facility shall immediately notify local law enforcement officials and cooperate fully with any investigation by them as set out in Section 630.168 RSMo, Supp. 1980. Color photographs shall be taken of the injuries as soon as possible. A physical examination shall be performed immediately.

			Department Operating Regulation Number DOR 2.205
Subject Abuse and Neglect Definitions, Investigation Procedures and Penalties	Effective Date 9/1/81	Number of Pages 4	Page Number 3

(5) The head of each facility shall establish a board of inquiry ("Board") to receive complaints, continue investigations as necessary, report findings, determine whether abuse or neglect occurred and recommend disposition of complaints to the head of the facility on DMH Form 8128.

(A) The head of the facility shall appoint at least five (5) members of the board at regional centers and at least ten (10) members to the board at mental health and mental retardation facilities. The board may be divided into subcommittees of at least three (3) members to investigate report, and recommend disposition of any complaints. At least one, non-supervisory, direct-care employee shall sit on each board or subcommittee which processes any complaint. No member may serve on the board or subcommittee to process a complaint of alleged physical abuse, sexual abuse, verbal abuse, class I neglect or class II neglect if the abuse and neglect occurred on his ward or unit.

(B) The board or subcommittee shall investigate by taking either written statements (DMH Form 8105) or tape recorded statements from witnesses to the alleged occurrences or statements from other persons who have relevant information.

(C) The board or subcommittee shall complete its investigation or report as soon as possible within ten (10) days of filing the complaint unless the head of the facility allows for a longer period of time on DMH Form 8107.

(6) After receiving a report containing findings of fact, the determination of whether abuse or neglect occurred and the recommended disposition, the head of the facility shall, within 7 days, do one of the following:

(A) Decide upon appropriate disposition of the matter;

(B) Remand the report to the board or subcommittee for further investigation and subsequent report. In which case, the board or subcommittee shall have not more than ten (10) days to complete its investigation and report to the head of the facility, unless the head of the facility allows for a longer period of time. (DMH Form 8107)

(C) Conduct further investigation himself for disposing of the matter. In which case, the head of the facility shall have an additional five (5) days to complete his investigation and dispose of the complaint.

(7) The head of the facility, within five (5) days after receiving the complaint, shall:

(A) Send a letter acknowledging the receipt of the complaint to the person who filed the complaint.

(B) Send a copy of the complaint to the client rights monitor designated by the department director to receive complaints.

Handout #2
(cont.)

Subject	Effective Date	Number of Pages	Page Number
Abuse and Neglect Definitions, Investigation Procedures and Penalties	9/1/81	4	4

Department Operating Regulation Number
DOR 2.205

(8) If the head of the facility finds an employee has committed physical abuse, sexual abuse, or class I neglect, then the head of the facility shall dismiss the employee.

(9) If the head of the facility finds that the employee has committed verbal abuse or class II neglect, the head of the facility shall discipline the employee under the department's progressive employment action guidelines.

(10) Pending the completion of the investigation, the head of the facility may suspend with pay on administrative leave, an employee or assign the employee to a non-client work area, if the safety of clients would be endangered if the employee continued to work.

(11) If the head of the facility decides to discipline the employee under this regulation, the head of the facility shall follow the usual disciplinary procedures under the department's progressive employment action guidelines. A pending criminal investigation or charges does not preclude the facility from processing complaints under this regulation.

(12) The complaint reports shall be confidential. The name of the complainant and other persons mentioned in the complaint shall not be disclosed except as necessary to process the complaint under this rule, unless the complainant or the other persons request disclosure or judicial or administrative proceedings are initiated. The facility should consult the facility attorney before disclosing the reports.

(13) The head of the facility shall send the client rights monitor copies of Complaint Forms (DMH Form 8108), Finding of Fact (DMH Form 8128), Request for Additional Investigation Time (DMH Form 8107) and dispositions by the head of the facility as they are submitted.

(14) The client rights monitor may communicate with members of the board or the head of the facility when necessary to provide consultation on investigations of unusual difficulty. The monitor may intervene to bring matters to the attention of the appropriate head of the facility, division director or department director. Upon direction of the appropriate division director or department director the monitor may initiate further investigation of a complaint. If requested by the department director, the State Advisory Council on Client Affairs may investigate a complaint as the department director's agent.

LESSON PLAN: 3

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT I : THE PSYCHIATRIC AIDE II AS A MEMBER OF THE TREATMENT TEAM

SCOPE OF UNIT:

This unit presents an overview of the Psychiatric Aide II Course and reviews key lessons and information taught in the Psychiatric Aide I Course that are considered essential knowledge necessary for the successful completion of this course. It also provides the student with an understanding of the team concept along with techniques that will assist in better utilization of time, communicating more effectively with the coworkers, and in promoting a better work environment.

INFORMATION TOPIC: I-3 OR DEMONSTRATION: ______

OVERVIEW OF COMMUNICATION SKILLS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT SHOULD BE ABLE TO:

1. Identify ten concepts of basic communication skills.
2. Identify three concepts of communicating with coworkers

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Handout #1: Therapeutic Communication Self-Evaluation Test

   (NOTE: This is to be used as a self-evaluation and classroom discussion tool.)

2. Handout #2: Therapeutic Techniques
3. Trainex filmstrip PC 294: "Verbal Barriers to Communication
4. Trainex filmstrip PC 293: "Effective Listening"
5. Trainex filmstrip PC 290: "Effective Speaking"
6. Trainex filmstrip PC 295: "Nonverbal Barriers to Communication"

INFORMATIONAL ASSIGNMENT:

Heimericks, Belinda. Psychiatric Aide I. Columbia, MO: Instructional Materials Laboratory, University of Missouri-Columbia, 1982, pp. 67-137.

REFERENCES: (Instructor's Additional Information)

INTRODUCTION:

Communication will be your primary technique in the psychiatric nursing care you give your patients. If you communicate effectively, you will probably be successful in developing therapeutic aide-patient relationships. The information we will cover in today's lesson was taught in depth in your Psychiatric Aide I Course. This information is essential to your knowledge if you are to function effectively as a Psychiatric Aide II, therefore, it is necessary to review the key points of those lessons.

LESSON PLAN: 3

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT I: THE PSYCHIATRIC AIDE II AS A MEMBER OF THE TREATMENT TEAM

INFORMATION TOPIC: I-3

OUTLINE: (Key Points)

I. Key Concepts of Basic Communication Skills

  A. Six elements of communication

    1. Sender

    2. Message

    3. Channel of transmission

    4. Receiver

    5. Response

    6. Feedback

  B. Verbal communication

    1. Definition: usually a voluntary act which transmits a message using a language.

    2. Types

  C. Nonverbal communication

    1. Definition: Does not depend upon words. It expresses feelings or emotions in other ways.

    2. Types

  D. Barriers that prevent communication

    1. Changing the subject

    2. Belittling other's feelings

    3. Believing that you know what the patient means

    4. Giving false or inappropriate responses

  E. Other reasons why messages are missed

1. Deafness
2. Difficulty speaking
3. Slowing down of understanding
4. Different language
5. Mental retardation

F. How hearing and listening differ

1. Hearing is defined as a passive awareness of sound.
2. Listening is defined as an active, conscientious attempt to hear what the message is and what it means.
3. Listening is an art and skill which involves control and mastery of the skill.

G. Tips for effective listening

1. Concentrate and pay close attention to what is being said.
2. Look at the person who is speaking.
3. Be alert when listening.
4. Try to put aside your own prejudices and values.
5. Be empathetic. (See Handout #1.)

H. Barriers and roadblocks in listening

1. On-off listening
2. Open ears-closed mind listening

I. Communicating effectively

1. Show an interest
2. Allow time for talking

J. Key points to remember in asking and answering questions

1. Reasons why patients ask questions
2. Tips on answering direct questions
3. Refer to other resources when appropriate.

K. Improving communication

1. Tone and manner
2. Timing of your response
3. Recognition of anxiety
4. Ward atmosphere

L. Techniques That Promote a Therapeutic Relationship

1. Use silence when necessary.
2. Accept the patient as a worthwhile individual and give him/her recognition such as calling by name.
3. Be available and check back with the patient periodically.
4. Give broad openings for the patient to talk about what is on his/her mind.
5. Make observations and verbalize these to the patient such as, "You appear tense."
6. Restate in different words what the patient has said.
7. Reflect back on what was said by saying, "You were saying?"
8. Remain open-minded; don't be judgmental.
9. Be honest.

M. Undesirable topics of conversation

II. Concepts of Communicating With Co-Workers

A. Key points to remember

1. Be yourself.
2. Be factual.
3. Be courteous.

B. Key points to remember about groups

1. Groups have stages that must be worked through.
2. Change slows down the workings of the group.

C. Stages of a group

1. Orientation
2. Trust

3. Self-assertion
4. Intimacy
5. Identity
6. Equilibrium

III. Summary and Conclusion

A. Key concepts of basic communication skills

B. Concepts of communicating with co-workers

In this lesson, we have reviewed the key points of verbal and nonverbal communication that are essential skills in our work with patients.

LESSON PLAN: 3

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT I : THE PSYCHIATRIC AIDE II AS A MEMBER OF THE TREATMENT TEAM

INFORMATION TOPIC: I-3

INTERACTION ITEMS:

1. Why is it important to develop good communication skills?
2. What are some barriers to communication and how can they be overcome?
3. Why is listening an important communication technique?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

1. Administer and discuss the Therapeutic Communication Self-Evaluation Test.
2. Show Trainex filmstrips from the PA I Course, Unit II: Communication. Selection based upon the needs of the students.
3. Have the students suggest a situation in which they had difficulty communicating with a patient. Have the student role play the situation with the instructor. The instructor should play the role of the aide. The instructor should demonstrate appropriate communication techniques. The instructor may want the students to suggest appropriate responses to the situation.

Handout #1

THERAPEUTIC COMMUNICATION SELF-EVALUATION TEST

Excerpt 1

"It's an awfully hard decision to make. I've got the chance to take the job at this other hospital. It's just the kind of aide position I'd like...pays better, too. But you've all been so wonderful to me, and I know how short of aides you are. Besides, I've been happy here and...well, you've really done a lot for me. Still, this other job is a real opportunity...oh, boy! I just don't know what's the right thing to do."

A. Well now, that shouldn't be too difficult. Let's weigh your reasons for taking the other job against your reasons for staying here and we should come out with a solution.
B. Indecisiveness is something you'll want to overcome. I think you'll find it much easier just to make your mind up about what it is you want and then act accordingly.
C. I gather you'd like to take this other job, but you're not sure you'd be doing the right thing by us.
D. Well, that's something you'll have to decide for yourself. But, remember, there are other things besides your own advancement to consider.
E. Tell me what your duties would be at the new hospital.

Excerpt 2

"I'm afraid to be alone. I really am. I get so depressed. It's unreal, but it's there. I get so worked up, I could scream. I'm afraid to tell my doctor about this fear, I'm afraid she'll order the laboratory tests and tell me it's cancer. My mother had it...my grandmother, my aunt. I've lived with it all my life, and it's hell. See, I break out in a sweat just talking about it.

A. Aside from your fear, have you experienced any symptoms which lead you to think you really might have cancer?
B. This terrific fear just never lets you alone.
C. If you have any reason at all to think you might have cancer, you really should try to control your fear enough to tell your doctor and let her do the proper examination.
D. Would you like to try this: whenever you experience one of these fears, ring for me, and I'll come in and talk it over with you. Talking it over sometimes helps a person to get a grip on himself/herself.
E. Whether you like it or not, I'm telling your doctor about it, so that he/she can do the tests. Cancer is nothing to play around with.

Excerpt 3

"I don't know how much longer I can keep my temper! That patient is impossible! He refuses to wash for breakfast, gripes about the food, and shouts at me...and he's always talking about religion and praying! I've tried all sorts of things...I've been friendly, I've asked him to cooperate, tried to reason with him, I've even pleaded with him to be more considerate. Nothing works. I've taken about all I can...it wouldn't take much more for me to tell him off...but good!"

A. Every once in a while we get a patient like that and he's just hurting himself.
B. It sounds like a rough situation, but it's important that you don't let him get the best of you.
C. Give me a little more detailed description of some of the incidents so I can get some idea of how you might handle him.
D. A good aide learns to handle all kinds of people! It's part of your job, so you'll have to learn.
E. It's pretty exasperating! You've taken a lot and now you feel it's about time for him to be on the receiving end!

Excerpt 4

"No, thank you, P.A. II. I think I'd rather not go down to the patients' party. I just don't feel comfortable in groups. You know, I've lived in this town for ten years now - and in the same apartment for seven years - but I don't know anybody. At the office I just can't seem to make friends. I just freeze up. I try to be nice to the other workers, but I feel all stiff and uncomfortable inside. And then I tell myself that I don't care, that people aren't dependable; that everyone is out for themselves. I don't want any friends - and sometimes I think I really mean that."

A. You should arrange to join a small social group at the "Y". I know several people who've done that. It'll give you something to do and help you make friends slowly...at your own pace.
B. Possibly if you could tell me a little more about how you go about trying to make friends, we could get a clearer idea of what is involved.
C. This has gone on for so long it almost has you convinced; is that what you mean?
D. That's pretty serious. Don't you think you'd better see a psychiatrist? Being without friends all your life could lead to real abnormal behavior.
E. That's a pretty unhappy situation, to be without friends, and one that I would really work on. There are a number of things that you might do to learn how to make friends and the sooner you start the better.

F. Let's go down to the patients' party together and have some refreshments. We can return to the unit anytime that you tell me you're becoming uncomfortable.

Excerpt 5

"Look at all those patients enjoying themselves with their visitors. I wonder why my husband hasn't shown up today. This is the second time he hasn't shown up at visiting hours. Sometimes it makes you wonder whether he really cares about me, although I know he is very busy on his job."

A. If your attitude toward your husband is anything like it is to the staff, I can readily understand why he'd want to stay home.
B. Although your husband might have some good reason for not coming today, I think he certainly should have phoned you to let you know he couldn't make it.
C. You feel sort of left-out of things and neglected when your husband doesn't visit.
D. Has there been any difficulty between you and your husband?
E. Well, suppose you call him at work, just to reassure your-yourself that he is very busy.
F. Why don't you call your husband and tell him that you miss his visits? If his working hours interfer with visiting hours, perhaps the visiting hours could be adjusted to accommodate his schedule.

Excerpt 6

"I've been married four times and each time I've thought, 'Boy, this is the real thing!' But none of them has ever been like this guy. He's the most handsome man you ever saw. And dance! And he dresses like a million dollars. He's out of sight!"

A. You're really enthusiastic about him.
B. How does he compare with your other husbands? How did you feel about them before you married?
C. If he's anything like you seem to feel he is, he must be quite a catch. Maybe this time you'll stick.
D. Doesn't it strike you as odd that every time you've felt this way?
E. Just stop and analyze what you've said. The points which you mention as his good points are rather superficial. You are still a bit immature, I'm afraid.

Excerpt 7

"I'm really burned up (tearfully)! I realize I made an error in the way I collected the specimen, but I don't think the head nurse was right in chewing me out in front of other aides. Everyone makes mistakes and this one wasn't too serious. What right does she have to ridicule me?! I'm so ticked, gosh! I don't care what happens!"

A. A mistake in nursing can be a serious matter. So when you make a mistake in training, you've really no right to expect sympathy.
B. Don't let the head nurse's remarks get you down. I'm sure she didn't mean to upset you. When you get better acquainted with her, I know you'll get along with her all right.
C. The head nurse has the very important responsibility of seeing that we follow the correct procedures. You can learn a lot from her if you use her criticisms constructively rather than becoming angry at her.
D. It was a very upsetting experience and you feel pretty angry and hurt at the head nurse. Her criticism could have been given somewhere else.
E. Maybe if you tell me how this came about, I could get a clearer picture of the situation.

Excerpt 8

"I tell you I hate that doctor of mine. I hate him! I hate him! I ask him about my diagnosis and he gives me the brushoff. Tells me a diagnosis hasn't been made yet. Hell! It makes me feel so terrible that I hate him so...especially when I have to count on him to get me well. I...it worries me."

A. You're certainly not acting very grown up. These doctors know their business. You do an awful lot of complaining about something that you're getting free.
B. I guess most patients go through a period when they don't like their doctors. It's really not at all uncommon. I hear that from most patients. But things eventually settle down.
C. This is certainly something you'll want to get straightened out. A good relationship with your doctor is important for your recovery. You'll find he'll treat you better if you can make yourself have faith in him.
D. You're concerned about how sick you really are, and it worries you not to know for sure what your doctor thinks.
E. Is there anything else your doctor has done to upset you besides not telling you your diagnosis?

Excerpt 9

"Congenital physical handicap! I can't do any of the things my sister does. I can't dance or go riding or date boys. I'm a ...look Charlene...I wish I was like her. You can't know the feeling I get deep inside me - I want to be able to have pretty clothes like hers and to go out and have a good time. It makes me sick inside - but she can't help it because I was born this way - and I get this feeling. I love my sister. Really I do--but I just cried and cried...only human. I know it's a sin to feel as I do, but she has everything and I have nothing!!!

A. Since you aren't going to be able to do the things your sister does, I'm wondering if there aren't some other activities which might be satisfying.
B. I can appreciate why you'd envy her so but since you can't compete with her it's not much use in using your energies with envy. You've got to build a world that satisfies you.
C. You're saying you feel envious of your sister because you can't compete with her and you feel guilty about your envy because you love her.
D. I'd like to know just how you react to her directly and how she reacts to you in some of these situations.
E. You say in one breath that you envy your sister and in the next that you love her. Now which is it?

Excerpt 10

"I really don't know what to do when I leave the hospital. Ah...I really don't know whether to go back to teaching school. It gets on my nerves so--I can hardly stand it...but I've got tenure and a good salary. Or else I could make a clean break and really do the thing I'm interested in. But that would mean starting in at the bottom with a very small salary and I wouldn't know whether I could do that or not.

A. Could you tell me more about your new field of interest?
B. Well, before you jump into something new you should be very sure that it is really more worthwhile and will provide at least the security and feeling of contribution that teaching brings.
C. Possibly we can help you with that decision. You know we have a vocational advisor right here in the hospital. He can give you tests which will furnish you with some idea as to whether you might expect to be successful in the line of your new interests.
D. I can't see where it would be a very wise thing to change occupations at your age. After all, you have three children who depend on you.
E. It's really a tough decision, isn't it? Whether to take risks of starting out in the new field or whether to stick by the security of an irritating teaching job.

Excerpt 11

"I've decided that these group meetings for my alcoholism aren't going to help me. All they do is make me realize what I have to do...I've decided to leave the hospital against medical advice."

Excerpt 12

"I'm really happy to have found an aide like you. I didn't know any existed. You really seem to understand me and that's really a great feeling. I feel like I'm coming alive again...and I haven't felt that way in a long time."

Excerpt 13

"When I'm feeling discouraged, I wonder if there will ever be anything that will appeal to me again. Maybe I've lived my life. Maybe that time in California was the best I will ever see, and from here on it will just be pretty second rate in comparison."

Excerpt 14

"I'm really excited the way things are going at home with my husband. It's just amazing! We get along great together now. Sexually, I didn't know we could be that happy."

Prepared by: Mid-Missouri Mental Health Center

ANSWERS TO THERAPEUTIC COMMUNICATION SELF-EVALUATION TEST

Excerpt

1. C
2. D
3. C
4. F
5. F
6. A
7. E
8. D
9. C
10. E

11-14. To be evaluated by instructor

Handout #2

THERAPEUTIC TECHNIQUES

1. SILENCE

SUPPORTIVE: Sitting with a patient who is withdrawn and non-communicative in silence is supportive as it provides reassurance that he/she is not alienated, shows concern, interest and acceptance, etc.

CONFRONTIVE: It often encourages the patient to verbalize if it is an interested and expectant silence conveyed by non-verbal expression. However, must be interested, as even momentary loss of interest can be interpreted as indifference.

REFLECTIVE: Allows the patient to collect his/her thoughts, think through a point, reduces pace of interview when either patient or staff is pushing too hard. Allows time to observe non-verbal cues or to assemble own thoughts.

2. ACCEPTANCE

Ex. "Yes"
"I follow what you said"
Nodding head

1. Indicates you have heard and follow trend of thought.
2. Signifies you are attuned to the patient, communication is occurring.
3. Indicates that you are participating and not a passive observer.
4. It does not indicate agreement but instead "Go on - it is safe for you to express how you feel."
5. It is non-judgmental (be sure your facial expression, tone of voice and posture do not indicate otherwise).

3. GIVING RECOGNITION

Ex. "Good morning, Mr. S."
"I noticed you have on a new shirt."
"You have tooled a leather wallet."

1. To greet by name indicates personage, as an individual.

2. Indicates awareness of change and efforts made.

3. It does not carry with it praise or approval. It merely acknowledges a fact, because if one thing is "good" or "nice" the opposite is "bad" or "not nice."

4. OFFERING SELF

Ex. "I'll sit here with you"
"I'm interested in you"
"I'll wait"

Making oneself available is therapeutic and must be made unconditionally; i.e., without patient's feeling that he/she must give in order to receive or that nurse will stay only if he/she does or does not do this or that.

5. GIVING BROAD OPENINGS

Ex. "Is there anything you would like to talk about?"
"Where would you like to begin?"
"Tell me about your past."
"Begin any place."

1. Allows the patient to set the direction of the conversation.

2. Gives the patient an opportunity to begin to express himself/herself.

3. Allows staff to focus conversation on the patient.

4. Avoid conventional pleasantries and idle small talk; instead, keep goal oriented.

6. OFFERING GENERAL LEADS

Ex. "Go on..."
"And then what?"
"Um Hmm."
"You were saying that..."

1. Encourages patient to continue.

2. The patient directs the converstaion.

3. Indicates you are following and are interested in what is to come next.

7. PLACING EVENT IN TIME OR SEQUENCE

Ex. "What seemed to lead up to..?"
"Was this before or after..?"

1. Clarifies relationship of events.
2. Helps both to see things in perspective.
3. Events can be viewed more objectively once a certain amount of chronology has occurred.
4. Helps to identify recurring patterns of diffculties.
5. Helps to find the kind of satisfying relationship patient needs.

8. ENCOURAGING DESCRIPTION OF PERCEPTIONS

1. This provides us with his/her internal frame of reference.
2. If the nursing staff is to understand the patient, we must come to see things as things seem to the patient. It provides an understanding of behavior and the needs that he/she is attepmting to meet.
3. They should be encouraged and made to feel free to describe their perceptions. It helps to prevent behavior that is to their detriment, discourages repression, and provides a basis of understanding.

9. MAKING AND SHARING OBSERVATIONS

Ex. "You appear tense."
"Your hands are tightly clenched."
"Your voice sounds tearful."
"I notice you bite your lip when..."

1. Verbalizing what is perceived brings observations to awareness, either for clarification or mutual understanding (many times patient is unaware of the behavior).
2. Conveys interest and concern.
3. The statements should reflect that it is your observation, using such terms as "seem" or "appear", or ask, "Am I wrong?" This prevents the patient from feeling threatened.

4. Sharing observations with the patient gives him/her an opportunity to verify, correct, or elaborate. This prevents the nursing staff from assuming we know the meaning of the patient's behavior.

10. ENCOURAGING COMPARISON

Ex. "Was this something like..?"
"Have you had similar experiences?"

1. Asking that similarities and differences be noted brings out many recurring themes.

2. Seeing similarities helps patient see or become aware of the continuity in his/her life.

3. Noting differences helps him to evaluate the influence of each event or person individually.

4. It is rarely helpful for staff to use experiences from our own life as it tends to focus on our own needs and problems.

11. RESTATING

Ex. Patient: "I can't sleep. I stay awake all night."
Nurse: "You have difficulty sleeping?"

1. Repeating the main idea as expressed by the patient gives evidence that the idea has been communicated.

2. Encourages patient to continue or elaborate.

3. If there is a misunderstanding he/she can reword and restate until he/she makes himself clear.

12. REFLECTING

Ex. Patient: "Everyone ignores me."
Nurse: "I ignore you?"
Patient: "Do you think I should tell the doctor..."
Nurse: "Do YOU think you should?"

1. This redirects the responsibility back to the patient.

2. It encourages elaboration.

3. Acknowledges his/her right to make deci-

sions, and states that we expect him/her to do so. He/she comes to see himself/herself as a capable person.

4. This technique should be used sparingly as it can become annoying.

13. FOCUSING OR SELECTIVE REFLECTING

Ex. "This point seems worth looking at more closely."

1. The staff member selects what he/she thinks is the most important idea in a series of statements or phrases the patient says, and directs this back to him/her.

Ex. Patient: "I feel so tired, I don't like it here."
Nurse: "Tired? or "YOU don't like it here?"

2. Especially useful when patient jumps rapidly from one thought to another.

14. EXPLORING

Ex. "Tell me more about your sister."

"Would you describe it more fully."

1. Many patients deal only superficially with each topic they bring up, as if to say nothing of importance has happened in their lives, to test your interest, or to avoid the pain of further discussion or elaboration.

2. Once a theme or trend has been identified, it should be explored, but refrain from probing if patient chooses not to elaborate.

15. GIVING INFORMATION

Ex. "My purpose in being here..."
"I'm taking you to..."
"The visiting hours are..."

1. Make available all the facts the patient needs. Alleviates anxiety.

2. Inform patient of the facts when he/she asks questions as it serves to build trust, as well as providing him/her with

the body of knowledge upon which to make decisions. If you do not know either, find out, or refer him/her to one who can be of assistance. This establishes an atmoshpere of helpfulness and trust in the Nurse-Patient relationship.

16. SEEKING CLARIFICATION

Ex. "I'm not sure I follow."
"Are you using this word to mean...?"

1. Always seek to make clear that which is not meaningful or that which is vague. Clarification should be sought at each step whenever there is any doubt in mutual understanding; otherwise communication is not taking place.

2. Don't hesitate to interrupt whenever in doubt as to meaning, and have patient identify "he" or "they". It is imperative that the words conveying ideas and concepts have essentially the same meaning for all participants.

17. PRESENTING REALITY

Ex. "I see no one else in the room."
"You are David Smith."
"Your mother is not here. I am the nurse."

1. Staff member indicates what is real, not by way of arguing or by belittling his/her own perceptions, but by calmly expressing one's own perception of the facts in the situation.

2. Reality orientation is particularly helpful with the geriatric patient who is confused and disoriented.

3. In the psychotic patient it provides an alternate line of thought for him/her to consider.

18. VOICING DOUBT

Ex. "Isn't the situation you've described a bit unusual?"
"It is difficult to believe."

1. Expressing uncertainty as to the reality of the patient's perceptions provides awareness that others do not perceive events in the same way (another way of presenting reality).

2. You have not agreed or disagreed, yet at the same time have not let misinterpretations go unheeded. It may encourage him/her to reconsider or re-evaluate the situation.

19. VERBALIZING THE IMPLIED

Ex. "I can't talk to you or anyone. It is a waste of time."
Nurse: "You are feeling that no one understands?"
Patient: "I'm dead."
Nurse: "Are you suggesting that you feel lifeless?"
Patient: I'm way out in the ocean."
Nurse: "You seem to feel deserted."

1. Many times patients are unable to clearly express what they are feeling, or their expressions may be symbolic. Staff should be sure to express only what is fairly obvious. This is another method of clarification in communication.

2. It is a method of voicing what the patient has hinted at or suggested.

3. It may be a method used by the patient to test to see if you are really striving to understand what he/she is feeling.

20. ENCOURAGING EVALUATION

Ex. "What are your feelings in regard to the...?"
"What do you think the problem is?"

1. It encourages the patient to evaluate the quality and nature of his/her experiences - how they affect him/her.

2. It places the responsibility upon the patient and discourages him/her from adopting without appraisal opinions and values of others.

21. SUMMARIZING

Ex. "You've said that..."
"What you have been telling me..."

1. Organizing and summing up what has been discussed is another method used in clarification in communication.

2. It brings together the important points of discussion, provides awareness of the progress made toward understanding,

and organizes the pertinent aspect of the interaction.

22. ENCOURAGING FORMULATION OF A PLAN OF ACTION

Ex. "What could you do to let your anger out harmlessly?"
"The next time this comes up what might you do to handle it?"

1. It places the responsibility back upon the patient for his/her behavior.

2. It shows respect for the patient in that you feel he/she is capable of making decisions for more appropriate behavior. Helps to develop insight.

NON-THERAPEUTIC INTERPERSONAL TECHNIQUES

1. REASSURING

Ex. "I wouldn't worry about..."
"Everything will be alright."
"You're coming along fine."

1. Attempting to dispel the patient's anxiety by implying there is not sufficient reason for it completely devaluates the patient's own feelings. No value is placed on his/her judgment.

2. It communicates a lack of understanding, creating negative feelings with the patient,and blocks him/her from expressing further feelings.

3. Often given automatically when we have a problem in knowing what to say.

4. It reduces our anxiety, making us feel more comfortable, but is meaningless to the patient. It blocks communication.

2. REJECTING

Ex. "Let's not discuss..."
"I don't want to hear about..."

1. This shows contempt for the patient's ideas or behavior. When the topic is rejected, it is closed off from exploration.

2. When the patient is rejected, therapeutic interaction ceases and he/she tends to avoid help so as not to risk further rejection.

3. Insecure personnel are likely to fear the patient's anxiety-producing experiences and give premature reassurances for their own protection.

3. DISAPPROVING

Ex. "That's bad"
"That is wrong"

1. Disapproval implies the right to pass judgment and that he/she is expected to please the other person. A patient's sick behavior is no more right or wrong, good or bad than physical pain.

2. Where a patient's actions may be harmful to others it is better to inform the patient of the effects of his/her actions than to offer value judgments.

3. Can cause anger and intimidate the patient.

4. If the patient accepts your disapproval, he/she may modify their behavior only to get your approval. This is not a healthy adjustment.

5. Instead of expressing disapproval you can ascertain the meaning of his/her statement or actions; for example, "You feel that...", "You seem to...", or share your observations of his/her behavior.

4. DISAGREEING

Ex. "I definitely disagree with..."
"I don't believe that."

1. Disagreeing implies that the patients are wrong and places personnel in opposition to the patients. It makes them feel that they must defend themselves and defending one's ideas tends to strengthen them. Thus, ideas that may very well be reinforced.

2. You can express your perceptions without showing disagreement.

5. ADVISING

Ex. "I think you should."
"Why don't you.."

1. This implies that he/she is incapable of self-direction.
2. It prevents patient from assuming responsibility for thinking through own problems and arriving at a decision that is right for him/her, as well as assuming responsibility for the outcome. If patient acts on your advice and things don't come out right you will be blamed.
3. Giving information differs from giving advice as it supplies the patient with additional data from which he/she can formulate judgment and action.

6. PROBING

1. Persistent questioning of the patient can cause him/her to become anxious or angry, particularly if he/she is not ready to face a particular situation. Therefore, you must be alert to these signs when questioning, so as to know when to terminate the questions.

7. CHALLENGING

Ex. "But how can you be president of the United States?"
"If you are dead, why is your heart still beating?"

1. Challenging puts the challenger in opposition to the patient.
2. Delusional ideas serve a purpose for the patient and are not readily given up. They conceal feelings and meet needs that are real to the patient.
3. Lessening the patient's need for such ideas with perceptions can best be accomplished by discovering the unmet needs and by then helping him/her meet those needs in reality situations.

8. DEFENDING

Ex. "This hospital has a fine reputation."
"No one would lie to you."
"I am sure he has your welfare in mind when..."

1. Attempting to protect someone or something from verbal attack implies that the patients have no right to express their impressions, opinions or feelings. It will not change their feelings.

2. When personnel are defensive, it is likely to create a negative reaction with the patient, causing him/her to withdraw or become hostile.

3. It places us in opposition to the patient.

9. REQUESTING AN EXPLANATION

Ex. "Why do you think that?"
"Why do you feel this way?"
"Why did you do that?"

1. This is asking the patient to provide reasons for his/her thoughts, feelings, behavior and events. A WHY question is intimidating. It asks for reasons which the patient does not know. He/she may resort to making up a reason.

2. It is much more helpful for the patient to describe "WHAT has happened or WHERE or WHEN."

10. INDICATING THE EXISTENCE OF AN EXTERNAL FORCE

Ex. "What makes you say that?"
"Who told you that you were Jesus?"
"What made you do that?"

1. Attributing the source of thought, feelings, and behavior to others or outside influences, implies that the patient was made or forced to think or act in a certain way. Such statements encourage the patient to use projection as a means of alleviating anxiety.

2. It is better to ask the patient WHAT happened...what events led you to draw such a conclusion?

11. BELITTLING FEELINGS EXPRESSED

Ex. "I have nothing to live for."
"I wish I were dead."

Nurse: "Everybody gets down in the dumps"
"I've felt that way, sometimes."

1. Equating the feelings of the patient with those of everybody or someone else or with oneself implies that the patient's discomfort is temporary, mild, or not unique. Such responses as "smile, buck up, think of something else, it could be worse," denote a lack of understanding, offer no constructive assistance, and serve to block communication.

2. When a patient is concerned with his/her own problems and misery, he/she is not capable of concern about the misery of others. Such responses make light of the problem and only add to the discomfort.

3. The staff can communicate understanding and acceptance by ACKNOWLEDGING the patient's feelings: "This must be very difficult, upsetting, etc., for you. Would you like to talk about it?"

12. MAKING STEREOTYPED COMMENTS

Ex. "Nice weather we're having."
"I'm fine, how are you?"
"Keep your chin up."
"Just listen to your doctor and take part in activities and you will be out of here in no time."

1. All impractical, meaningless comments should be avoided. Such meaningless conversation encourages likewise from the patient. It keeps the conversation on a superficial level.

2. Used many times to avoid uncomfortable topics. It is not goal-oriented; therefore, not therapeutic, and does not meet the need of the patient.

13. GIVING LITERAL RESPONSES

Ex. Patient: "I'm an Easter Egg."
Nurse: "What shade?" or "You don't look like one."

1. This is responding to a figurative comment as if it were a statement of fact. Many times patients will use figurative comments as it is the best way they have of putting into words the way they feel. Responding in such manner denotes lack of understanding and

avoids the real issue. Instead focus on the feelings associated with the statement.

15. USING DENIAL

Ex. Patient: "I'm nothing."
Nurse: "Of course you are something. Everybody is something."
Patient: "I'm dead."
Nurse: "Don't be silly."

1. Refusing to admit that a problem exists denotes a lack of understanding, blocks communication.

2. Help patient to explore further what these feelings mean to him/her and what they are associated with.

3. Such a method is used because it puts the staff members at ease due to not knowing what to say or how to explore the situation in an attempt to determine the real need.

15. INTERPRETING

Ex. "What you really mean is..."
"Unconsciously you are saying..."

1. The interpretation may be incorrect or the patient may not be ready for it; it keeps the patient from gaining insight on his/her own.

2. Very few people feel comfortable in being exposed. Instead redirect the question to help patient make his/her own conclusions.

16. INTRODUCING AN UNRELATED TOPIC

Ex. Patient: "I'd like to die."
Nurse: "Did you have visitors this weekend?"

1. Shows disrespect and lack of concern for the patient feelings and immediate needs.

17. GIVING APPROVAL

Ex. "That's good"
"I'm glad that you..."

1. Approval tends to limit the patient's freedom to think or act in a way that displeases others. It leads the patient to strive for praise rather than progress.

2. Patient must make decisions that he/she is comfortable with and pleases him/her or gives a sense of self-worth, not make decisions according to the standards of others.

18. AGREEING

Ex. "That's right."
"I agree."

1. This gives the impression that he/she is right because his/her opinion is the same as yours. It limits the patient in modifying or changing views later on.

2. Opinions and conclusions should be exclusively the patient's and not yours.

LESSON PLAN: 4

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT I : THE PSYCHIATRIC AIDE II AS A MEMBER OF THE TREATMENT TEAM

SCOPE OF UNIT:

This unit presents an overview of the Psychiatric Aide II Course and reviews key lessons and information taught in the Psychiatric Aide I Course that are considered essential knowledge neccessary for the successful completion of this course. It also provides the student with an understanding of the team concept along with techniques that will assist in better utilization of time, communicating more effectively with the coworkers, and in promoting a better work environment.

INFORMATION TOPIC: I-4 OR DEMONSTRATION: _______

THE TEAM CONCEPT
(Lesson Title)

LESSON OBJECTIVE - THE STUDENT SHOULD BE ABLE TO:

1. Match the name of the interdisciplinary treatment team member with the unique contribution of that discipline to the team.
2. Identify three roles the Psychiatric Aide II has in a treatment team meeting.
3. Identify four roles the Psychiatric Aide II has while in the unit.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Handout #1: The Nursing Team
2. Handout #2: Competencies of A Psychiatric Aide II

INFORMATIONAL ASSIGNMENT:

Heimericks, Belinda. Psychiatric Aide I. Columbia, MO: Instructional Materials Laboratory, University of Missouri-Columbia, 1982, pp. 17-22.

REFERENCES: (Instructor's Additional Information)

Choroscavich, Gertrudo D. A Textbook for Nursing Assistants. 3rd ed., St. Louis: C.V. Mosby Company, 1973, pp. 9-14.

Haber, Judith, et al. Comprehensive Psychiatric Nursing. St. Louis: McGraw-Hill Book Co., 1978, pp. 137.

Pasquali, Elaine A., et al. Mental Health Nursing: A Bio-Psycho-Cultural Approach. St. Louis: C.V. Mosby Company, 1981, pp. 283-291.

INTRODUCTION:

The interdisciplinary team concept is an approach that encourages contributions toward patient care from all members of the team. The person who has the greatest expertise with a particular patient problem or has the best rapport with a patient is designated the team leader when developing a plan of care for that particular patient. Some facilities have a modified team approach in which the team members have equal representation, but one member is designated as and is always the team leader. The medical model is also used in many facilities. In this case, the physician is always the team leader and he/she gives the final approval on the plan of care. No matter who leads the treatment team, the patient is always the most important team member no matter how confused or disoriented he/she seems. In this lesson, we will discuss the team concept and your role as a member of the team.

LESSON PLAN: 4

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT I : THE PSYCHIATRIC AIDE II AS A MEMBER OF THE TREATMENT TEAM

INFORMATION TOPIC: I-4

OUTLINE: (Key Points)

I. Members of the Interdisciplinary Treatment Team
    A. Psychiatrist
        1. Physician with specialized training in psychiatry
        2. Is the team leader with the medical model
        3. Unique contributions
            a. Admits and discharges patients to the hospital
            b. Prescribes medications and procedures such as ECT
    B. Physician
        1. Medical internist or general practitioner who monitors the physical health of the patients
        2. Has the same unique contributions as the psychiatrist
    C. Clinical psychologist
        1. Educated at the doctoral level
        2. Has specialized training in individual, group, and family therapy
        3. Unique contribution: training in psychological testing which assists in diagnosing and treatment planning
    D. Social worker
        1. Primarily concerned with the family and community aspects of patient care
        2. Those trained at the master degree level are skilled in individual, family and group therapy.

            5) Communication patterns
            6) Personal hygiene habits
            7) Sleeping patterns
            8) Eating habits
            9) Socialization skills and patterns

        b. Establishes the necessary attitudes for therapeutic milieu

        c. Maintains the therapeutic milieu

        d. Coordinates the nursing care

        e. Role models mentally healthy behavior

        f. Nurtures, guides, supports, and teaches patients

        g. Assists the patient in expressing his/her needs to the treatment team

        h. Sees that the physical health needs of patients are met

        i. Administers and monitors the effects of medications

        j. Teaches appropriate behaviors for maintenance of physical and mental health

        k. Assists patients in their efforts to solve their problems

        l. Functions as the patient's advocate

        m. Guides the nursing care provided by the nursing team

H. Psychiatric aide

1. Varied educational and job history backgrounds

2. Are with the patient 24 hours a day.

3. Unique contributions of the Psychiatric Aide II (Review the Psychiatric Aide II Competencies p. 71.)

4. Give nursing care that requires observational abilities and skill as an assistant.

I. Other members of the treatment team

   1. Licensed practical nurse
   2. Art and music therapists
   3. Dietician
   4. Vocational rehabilitation counselor
   5. Education staff
   6. Auxiliary personnel
   7. Chaplain service

II. The Psychiatric Aide II's Role in a Team Meeting

   A. In some facilities, the Psychiatric Aide II may be asked to attend team meetings.

   B. The Psychiatric Aide II's responsibility in team meeting is to:

      1. Report observations about patient behavior.
      2. Report patient's response to treatment approaches.
      3. Suggest approaches for working with the patient.

III. The Psychiatric Aide II's Role as a Team Member While On the Unit

   A. The Psychiatric Aide II carries out assignments made by the nurse, such as:

      1. Perform nursing care to assigned patients based on the plan of care.
      2. Orient new employees by using a buddy system approach.
      3. Help assigned Psychiatric Aide I perform nursing care.
      4. Manages the ward for safety and cleanliness.

   B. The Psychiatric Aide II observes, reports, and records information about patient behavior.

   C. The Psychiatric Aide II assists the nurse in maintaining a therapeutic milieu based on guidelines established by the treatment team.

D. The Psychiatric Aide II serves as a support person for the patient.

IV. Summary and Conclusion

A. Members of the treatment team

B. The Psychiatric Aide II's role in a treatment team meeting

C. The Psychiatric Aide II's role as a team member while on the unit

In today's lesson, we have discussed the team concept and the unique contributions of various members of the interdisciplinary team. We have also identified the Psychiatric Aide II's role during a team meeting and while on the unit.

LESSON PLAN: 4

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT I: THE PSYCHIATRIC AIDE II AS A MEMBER OF THE TREATMENT TEAM

INFORMATION TOPIC: I-4

INTERACTION ITEMS:

1. What is meant by being a support person for the patient?
2. Why does the patient need a support person?
3. What are the unique contributions of the nurse?
4. What are the unique contributions of the Psychiatric Aide II?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

1. Review the organizational structure of the facility.
2. Flash cards - name of team members on one side and their duties on the other side
3. Pin name of team member on back of student. Have student approach another student and ask three questions related to the discipline. Then try to guess the discipline title pinned on his/her back.

Handout #1

THE NURSING TEAM

The nursing team consists of the Registered Nurse, other nurses and psychiatric aides providing nursing care on a specific unit.

The head nurse is the leader of the nursing team by virtue of the extensive education regarding nursing care of the sick. It is his/her duty to coordinate all nursing care.

The duty of the aide is to assist the nurse by performing functions for which he/she has been trained. The nurse assigns the aide certain tasks to perform based on that person's skill and training.

The assignment should indicate the patients he/she is to care for, what observations should be made, which observations should be reported immediately, what care the aide is to give and how it is to be given, and what care the nurse will ge giving.

This information should be discussed in a nursing care conference which ideally should be held at the beginning of each shift. This is also the time that care given should be evaluated and recommendations for the plan of care discussed.

One assignment that may be requested of a Psychiatric Aide II, is that he/she assist a Psychiatric Aide I and/or Hospital Attendant I in performing their assigned care. As a Psychiatric Aide II with additional training and expertise, you are able to share your knowledge and skills with the other aides.

Remember that the goal of the nursing team is better patient care provided by the nurses and psychiatric aides working together.

Handout #2

Competencies Of Psychiatric Aide II

Student Final Record
Psychiatric Aide II - Mental Health Care

Name of Student ______________________________
(Last) (First) (Middle) (Maiden)

Mental Health Facility ______________________________

Permanent Address ______________________________ Soc. Sec. No. ______________

Date Started ______________ Date Completed ______________ Theory Grade ______________

Instructor(s) ______________________ ______________________
(Signature) (Signature)

______________________ ______________________
(Signature) (Signature)

Personal/Professional Competencies Performed Under the Direction of the Registered Nurse	Unsatisfactory	Satisfactory
1. Observes, reports and records information about the patient in reference to the plan of care.		
2. Carries out nursing interventions based on the patient's behavior and the plan of care.		
3. Supports and protects patients by respecting their rights.		
4. Assists the Registered Nurse in preventing and managing assaultive behavior.		
5. Assists the Registered Nurse in providing nursing care to the patient in seclusion and/or restraints.		
6. Monitors suicidal and homicidal patients.		
7. Develops therapeutic relationships with patients.		
8. Participates in patient support groups.		
9. Recognizes and reports to the Registered Nurse the expected and major adverse effects of psychotropic medications.		
10. Assists in maintaining a therapeutic milieu on the unit.		
11. Assists in managing the environment for cleanliness and safety.		
12. Assists in the orientation of HA I's.		
13. Participates as an active member of the treatment teams.		
14. Assumes accountability for his/her duties.		
15. Models mentally healthy behavior.		
16. Participates in self-development through inservice education.		

Average Score ______________

While in Psychiatric Aide II class, I have also received training/practice in the following:

First Aid________________ CPR________________

Additional Comments:

Student ____________________________ ____________________________
(Signature)

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LESSON PLAN: 5

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT I: THE PSYCHIATRIC AIDE II AS A MEMBER OF THE TREATMENT TEAM

SCOPE OF UNIT:

This unit presents an overview of the Psychiatric Aide II Course and reviews key lessons and information taught in the Psychiatric Aide I Course that are considered essential knowledge neccessary for the successful completion of this course. It also provides the student with an understanding of the team concept along with techniques that will assist in better utilization of time, communicating more effectively with the coworkers, and in promoting a better work environment.

INFORMATION TOPIC: I-5 OR DEMONSTRATION: ______

PLANNING AND ORGANIZING YOUR WORK
(Lesson Title)

LESSON OBJECTIVE - THE STUDENT SHOULD BE ABLE TO:

1. Identify four reasons for planning and organizing your work.
2. Identify four techniques for planning and organizing your work.
3. Identify five steps of the problem solving process.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

INFORMATIONAL ASSIGNMENT:

REFERENCES: (Instructor's Additional Information)

Diekelmann, Nancy L. and Broadwell, Martin M. The New Hospital Supervisor. Reading, Mass.: Addison-Wesley Publishing Company, 1977, pp. 45-56.

Lakein, Alan. How to Get Control of Your Time and Your Life. New York: Signet, 1973.

INTRODUCTION:

As a Psychiatric Aide II, you are expected to function at a higher level with greater skill and expertise in your work than when you were a Psychiatric Aide I. In order to further your skills and accomplish more on the job, you must plan and organize your work efficiently. Planning and organizing skills do not come naturally. They, too, must be learned. In today's lesson, we will discuss why it is important to plan and organize, and techniques for planning and organizing. We will also discuss the steps of the problem solving process.

LESSON PLAN: 5

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT I : THE PSYCHIATRIC AIDE II AS A MEMBER OF THE TREATMENT TEAM

INFORMATION TOPIC: I-5

OUTLINE: (Key Points)

I. Planning and Organizing Your Work Enables You To:

   A. See the whole picture.

   B. Accomplish specific tasks.

   C. Stay on course.

   D. Work in a careful manner rather than haphazardly.

II. Techniques For Planning and Organizing

   A. Identify and list the tasks to be accomplished.

      1. Be specific about the task.

      2. Break it down into small steps, if it is a large task.

   B. Prioritize the tasks.

      1. Identify those tasks that must be accomplished immediately.

      2. Identify those tasks which can be accomplished later.

      3. Identify those tasks which can be started today and finished tomorrow.

   C. Establish a flexible timetable.

      1. This prevents you from postponing tasks until the last minute.

      2. Use your assignment sheet as your worksheet.

D. Delegate tasks or work when appropriate. Clearly identify:

   1. What is to be done.
   2. Who is to do what.
   3. How it is to be done.
   4. When it is to be done.

III. The Problem Solving Process

   A. Identify the problem.
   B. Gather information.
   C. Develop a plan of action.
   D. Act on the plan.
   E. Evaluate the results.

IV. Summary and Conclusion

   A. Planning and organizing your work
   B. Techniques for planning and organizing
   C. The problem solving process

In today's lesson, we have discussed the reasons why it is important to plan and organize your work. We have also discussed techniques for planning or organizing and the steps of the problem solving process.

LESSON PLAN: 5

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT I : THE PSYCHIATRIC AIDE II AS A MEMBER OF THE TREATMENT TEAM

INFORMATION TOPIC: I-5

INTERACTION ITEMS:

1. Why is it important to plan and organize your work?
2. What are some techniques for planning and organizing?
3. What are the steps of the problem solving process?
4. Why is it important to know the problem solving process?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

1. Have the students list the tasks they would be expected to accomplish during the shift. Have them plan, organize and prioritize their work on an assignment sheet.
2. Assign each student a hypothetical task to be completed with another person. Have each student plan the task identifying what, who, how and when.
3. Assign each student a hypothetical problem. Have them use the problem solving process to develop a plan for soving the problem.

LESSON PLAN: 6

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT I : THE PSYCHIATRIC AIDE II AS A MEMBER OF THE TREATMENT TEAM

SCOPE OF UNIT:

This unit presents an overview of the Psychiatric Aide II Course and reviews key lessons and information taught in the Psychiatric Aide I Course that are considered essential knowledge neccessary for the successful completion of this course. It also provides the student with an understanding of the team concept along with techniques that will assist in better utilization of time, communicating more effectively with the coworkers, and in promoting a better work environment.

INFORMATION TOPIC: I-6 OR DEMONSTRATION: ______

COMMUNICATING EFFECTIVELY WITH COWORKERS
(Lesson Title)

LESSON OBJECTIVE - THE STUDENT SHOULD BE ABLE TO:

1. Identify nine key points to remember when communicating with others.
2. Identify five tips that will help in developing a trusting relationship with coworkers.
3. Identify three styles of communication.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

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INFORMATIONAL ASSIGNMENT:

Heimericks, Belinda. Psychiatric Aide I. Columbia, MO: Instructional Materials Laboratory, University of Missouri-Columbia, 1982, pp. 93-97.

REFERENCES: (Instructor's Additional Information)

Bolton, Robert. People Skills. Englewood Cliffs, NJ: Prentice-Hall, Inc., 1979, pp. 123-125.

Diekelmann, Nancy L. and Broadwell, Martin M. The New Hospital Supervisor. Reading, Mass.: Addison-Wesley Publishing Company, 1977, pp. 31-38.

INTRODUCTION:

Throughout this course and the Psychiatric Aide I course, therapeutic communication with patients has been emphasized. But communication with patients is only a part of the total communication picture. It is equally important for you to be able to communicate with coworkers. You may be able to establish very therapeutic relationships with patients, but unless you are able to communicate the goals and progress of this with the coworker, your work is in vain. In today's lesson, information will be presented that will help you in communicating more effectively with coworkers.

LESSON PLAN: 6

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT I : THE PSYCHIATRIC AIDE II AS A MEMBER OF THE TREATMENT TEAM

INFORMATION TOPIC: I-6

OUTLINE: (Key Points)

I. Key Points to Remember When Communicating With Others

   A. People tend to communicate with people they can trust.

   B. People tend to communicate with people who satisfy their needs and make them feel secure.

   C. People tend to communicate with people who are supportive rather than critical.

   D. Communication is affected by the feelings and attitudes one has toward others.

   E. Communication is more accurate when those communicating like one another.

   F. Communication is less accurate when there is a feeling of distrust among those communicating.

   G. It is difficult to trust someone whose actions and communication are unclear and inconsistent.

   H. If there is a trust relationship, people are more open and honest about their true feelings.

      1. Behavior is less defensive.

      2. Behavior is more problem oriented.

   I. It is important for people to feel that they are a part of their peer group.

II. Tips That Will Help in Developing a Trusting Relationship With Coworkers

   A. Be consistent in your behavior.

   B. Do not repeat what someone has told you in confidence.

   C. Be supportive of others.

D. Be open and honest in your communication. Do not tell John one thing and Joe the opposite.

E. Remain objective, not judgmental.

F. Examine your attitudes and feelings. Be aware of your position.

G. Learn to listen to what the other is saying.

   1. Listen for the idea.

   2. Listen for what is behind the idea.

H. Tune out the distractions around you.

I. Learn to ask questions about the topic being discussed as an aid to learning.

J. Remember that the other person has needs, too.

III. Three Styles of Communication

A. Submissive style

   1. True feelings are not expressed

   2. Own needs are expressed apologetically

   3. Deny their own needs and feelings

   4. Believe their own opinions have no value

   5. Berate themselves

B. Aggressive style

   1. Selfish

   2. Immediate pay off

   3. Discount others

   4. Mechanical

   5. Puts down person - not just his behavior

   6. Better than

   7. "You" messages

C. Assertive Style (most productive)

   1. Self-fullfilling

2. Respects others but does not defer
3. Does not infringe on rights of others
4. Honest
5. Direct
6. Appropriate
7. Timely
8. Choice is present.
9. "I" messages

IV. Summary and Conclusion

A. Key points to remember when communicating with others

B. Tips that will help in developing a trusting relationship with coworkers

C. Three styles of communication

In today's lesson, we have discussed key points to remember when communicating with others, tips on developing trusting relationships, and three styles of communication. Now it is time for you to analyze the communication style that you use with coworkers.

LESSON PLAN: 6

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT I : THE PSYCHIATRIC AIDE II AS A MEMBER OF THE TREATMENT TEAM

INFORMATION TOPIC: I-6

INTERACTION ITEMS:

1. Why is it necessary to be able to communicate well with coworkers?
2. What are some points to remember when talking with others?
3. How do these points affect communication?
4. Why is it necessary to establish trust with your coworkers?
5. What are some tips for establishing trust?
6. Of the three styles of communication, which is the most desirable and why?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

1. Two instructors should role play a situation in which coworkers are trying to discuss a problem. First, one of the coworkers is not listening and the other coworker is feeling very frustrated because of this. Second, both coworkers are listening and are in tune with each other. After each role play, have the students describe and discuss the feelings they experienced as they observed.
2. Have the students voluntarily present situations in which it was difficult to communicate with a coworker. The group should brainstorm ways of dealing with the situation assertively.

LESSON PLAN: 7

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT I: THE PSYCHIATRIC AIDE II AS A MEMBER OF THE TREATMENT TEAM

SCOPE OF UNIT:

This unit presents an overview of the Psychiatric Aide II Course and reviews key lessons and information taught in the Psychiatric Aide I Course that are considered essential knowledge neccessary for the successful completion of this course. It also provides the student with an understanding of the team concept along with techniques that will assist in better utilization of time, communicating more effectively with the coworkers, and in promoting a better work environment.

INFORMATION TOPIC: I-7 OR DEMONSTRATION: ______

PROMOTING A THERAPEUTIC WORK ENVIRONMENT
(Lesson Title)

LESSON OBJECTIVE - THE STUDENT SHOULD BE ABLE TO:

1. Identify three reasons why it is important to promote a therapeutic work environment.
2. Identify four factors which promote a therapeutic work environment.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Film: The Patient as a Person (Cornet Films)

INFORMATIONAL ASSIGNMENT:

REFERENCES: (Instructor's Addition Information)

Diekelmann, Nancy L. and Broadwell, Martin M. The New Hospital Supervisor. Reading, Mass.: Addison-Wesley Publishing Company, 1977.

INTRODUCTION:

A satisfactory work environment is necessary for the mental health of the staff. The nurse is in charge of the unit, but he/she can only lay the groundwork for a therapeutic work environment. It is the responsibility of all staff to promote a satisfactory environment. In today's lesson, we will discuss what you as a Psychiatric Aide II can do to promote a satisfactory working environment.

LESSON PLAN: 7

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT I : THE PSYCHIATRIC AIDE II AS A MEMBER OF THE TREATMENT TEAM

INFORMATION TOPIC: I-7

OUTLINE: (Key Points)

I. Reasons Why It Is Important to Promote a Therapeutic Work Environment

  A. Improves quality of nursing care

    1. Patient's behavior improves.

    2. Staff is encouraged to continue improving the quality of care.

  B. Promotes job satisfaction

    1. People stay with the job longer.

    2. Absenteeism is reduced.

  C. Encourages individual growth among staff

    1. People who feel good about what they are doing will strive to do a better job.

    2. People strive to learn more.

II. Factors Which Promote a Therapeutic Work Environment

  A. Being able to cope with change

    1. Do not make a quick decision on the value of the proposed change.

    2. Do not fear change.

    3. Identify why change is necessary.

    4. Assertively express your opinions about the change.

  B. Avoiding the hospital "grapevine"

    1. People want to know what is going on. That is human nature.

        a. Try to find out the facts.

        b. Do not spread rumors.

        c. Remember: Gossip breeds distrust and misunderstanding.

    2. Confidentiality among coworkers is as important as it is among patients.

C. Keeping morale up

    1. Signs of good morale

        a. Thinks the job is good and coworkers are skilled

        b.. Likes the job and coworkers

        c. Works efficiently and utilizes time wisely

    2. Morale is affected by many little things.

        a. Physical condition of the work setting

        b. Feeling that people value your opinion

        c. Amount of overtime you are required to work

        d. Job status

    3. Specific things can build morale.

        a. Foster a spirit of teamwork.

        b. Assist coworkers maintaining a comfortable work environment.

        c. Display genuine concern for your coworkers.

        d. Value the opinions of others.

D. Reporting for duty when scheduled and discouraging absenteeism among coworkers

    1. Absenteeism creates additional workloads for your coworkers and a disruption in scheduling. This fosters low morale.

    2. Peer pressure is very effective in changing behavior.

3. Schedule an occasional holiday or vacation day so that you do not get "burned out" and call in sick. Advance scheduling is much easier to deal with than a last minute call-in.

III. Summary and Conclusion

A. Reasons why it is important to promote a therapeutic work environment

B. Factors which promote a therapeutic work environment

In today's lesson, we have discussed the importance in promoting a therapeutic work environment and factors which promote a therapeutic work environment.

LESSON PLAN: 7

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT I : THE PSYCHIATRIC AIDE II AS A MEMBER OF THE TREATMENT TEAM

INFORMATION TOPIC: I-7

INTERACTION ITEMS:

1. Why is it important to promote a therapeutic work environment?
2. Who has the responsibility of promoting a therapeutic work environment?
3. How does low morale affect the work environment?
4. How does absenteeism affect the work environment?
5. Why is it important to be able to cope with change?
6. Why is it important to avoid the hospital "grapevine"?

1. Have each student list factors which he/she consider important for a work setting to be satisfactory. Ask the students to discuss these factors with the class. Identify how many of the factors are actually present in the work setting. Make suggestions for promoting a more therapeutic work environment.
2. Role-playing some situations such as a patient who is usually cooperative, i.e., usually makes his/her bed, takes a bath voluntarily, helps with ward housekeeping, etc., suddenly refuses to do anything. A frustrated Psychiatric Aide I approaches the Psychiatric Aide II with the problem.

LESSON PLAN: 8

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT II : THE INDIVIDUALIZED TREATMENT PLANNING PROCESS

SCOPE OF UNIT:

This unit is designed to instruct the student about the individualized treatment planning process. Information will be given about how the plan of care is developed, the role of the Psychiatric Aide II in this process, how the Psychiatric Aide II will use the plan of care in his/her work, and how to chart in relation to the plan of care.

INFORMATION TOPIC: II-1 OR DEMONSTRATION: ______

UNDERSTANDING THE DEVELOPMENT OF AN INDIVIDUALIZED PLAN OF CARE
(Lesson Title)

LESSON OBJECTIVE - THE STUDENT SHOULD BE ABLE TO:

1. Identify seven key parts of a measurable goal.
2. Identify six reasons why it is important to develop goal-oriented treatment plans.
3. Identify five steps in developing a goal-oriented plan of care.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

Facility guidelines on treatment plan process

INFORMATIONAL ASSIGNMENT:

Heimericks, Belinda K. Psychiatric Aide I. Columbia, MO: Instructional Materials Laboratory, University of Missouri-Columbia, 1982, pp. 101-120.

REFERENCES: (Instructor's Additional Information)

Haber, Judith, et al. Comprehensive Psychiatric Nursing. St. Louis: McGraw-Hill Book Co., 1978, pp. 102-119.

Houts, Peter S. and Scott, Robert. Individualized Goal Planning in Mental Health Rehabilitation. Department of Behavioral Science, The Pennsylvania State University College of Medicine, The Milton S. Hershey Medical Center, Hershey, Pennsylvania, 1976.

Pasquali, Elaine A., et al. Mental Health Nursing: A Bio-Psycho-Cultural Approach. St. Louis: C.V. Mosby Co., 1981, pp. 237.

INTRODUCTION:

The individualized plan of care is a tool we use to assist us in providing humane treatment to the patient. It serves as the blueprint for us as we select nursing interventions. All members of the interdisciplinary treatment team make valuable contributions toward the development of the individualized plan of care. The patient should be considered the most important person and primary contributor in the planning process because the plan is for him/her. The patient will be expected to change behavior and, therefore, must actively support the plan. The patient alone determines the outcome.

As a Psychiatric Aide II, your role in the planning process will be to make observations and report and record them. The information you provide is very valuable to the team in their development of the plan. In this lesson, we will discuss the development of the individualized plan of care so that you will have a better understanding of its use.

LESSON PLAN: 8

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT II: THE INDIVIDUALIZED TREATMENT PLANNING PROCESS

INFORMATION TOPIC: II-1

OUTLINE: (Key Points)

I. Key Parts of a Measurable Goal

  A. It describes a change in behavior that the patient will make.

    1. The goal describes what the patient will do.

    2. The goal should never describe what the staff will do.

  B. The goal is written in measurable terms.

    1. Realistic

    2. Achievable

  C. The goal indicates to what degree the behavior will change.

  D. The goal will have a target date set for its accomplishment.

  E. Interventions will describe what the staff will do to assist the patient in completion of the goal.

  F. The goal should be written in simple terms so that everyone, especially the patient, can understand what is to be accomplished.

  G. The patient's strengths should be used in meeting his/her needs.

II. Reasons Why It Is Important to Develop an Individualized Plan of Care

  A. It is a tool to assist in providing more humane care to the patient.

  B. The patient and staff know what goals are to be accomplished.

  C. The goal is directed toward the patient.

    1. The patient knows what he/she is working to accomplish.

2. The staff can identify interventions for helping the patient accomplish the goals.

D. The staff can identify who is responsible for working with the patient on certain goals.

E. Target dates can be set for the accomplishment of goals.

F. Progress toward the goals can be measured.

III. Steps in Developing an Individualized Plan of Care

A. Information is gathered about the patient. The Psychiatric Aide II can make observations about the following:

1. Physical description

a. Appearance

b. Posture

c. Nonverbal expressions

d. Gestures and mannerisms

e. Dress

f. Eye contact

g. Motor activity

1) Restless

2) Hyperactive

3) Little movement

2. Communication

a. Main idea of conversation

1) Can the main idea be followed?

2) Does patient jump from topic to topic?

b. Speed of speech

c. Volume of speech

1) Shouts

2) Whispers

3) Mumbles

3. Oriented to time, place, person
    a. Does the patient know the date, day, and year?
    b. Does the patient know his/her name?
    c. Does the patient know where he/she is?
4. Relationship patient has with others
    a. Remains alone
    b. Sits with others but does not interact
    c. Attempts to join in conversation
    d. Monopolizes the conversation
    e. Well liked by others
    f. Guarded and defensive with others
5. Mood
    a. Sad
    b. Overly cheerful
    c. Tearful/crying
    d. Angry
    e. Hostile
    f. Anxious
    g. Worried
    h. Tearful
6. The nurse and other mental health professionals will gather further information about the patient's physical and mental status.
7. The Psychiatric Aide II should report observations to the head nurse and record them in the chart.

B. Inferences are made about the patient.
    1. Made by nurse and other mental health professionals only.
    2. The nurse uses information gathered by the Psychiatric Aide II and others to formulate opinions about the patient's strengths and needs.

3. Examples of inferences made by the nurse:

    a. The patient is unable to develop healthy relationships with other people.

    b. The patient is unable to meet his/her basic needs for food and shelter.

    c. The patient is unable to verbally express his/her needs.

    d. The patient expresses anger towards others by purposely physically harming self.

4. Inferences should be individualized to the patient and should state the patient's name.

C. A plan of care is developed.

1. Long term goals are established.

2. Short term goals are established.

    a. Based on long term goals.

    b. Identify behaviors to be changed in order to accomplish the long term goals.

3. Interventions are established.

    a. These are the staff actions that will assist the patient in achieving goals.

    b. Identify the staff responsible for assisting the patient.

4. A target date is set for each goal.

5. Each goal is measurable.

6. Each goal is achievable.

7. All goals and interventions are written so that the patient and all staff understand what is expected.

D. The plan is carried out.

1. The staff assigned shall use the interventions with the patient.

2. All nursing care must be based upon the interventions if the patient is to accomplish the treatment goals.

        3. The team approach is very important, because confusion resulting from varying approaches may cause a patient to regress or remain at his/her current level of functioning.

    E. Evaluate whether the plan is effective.

        1. Evaluation is on-going and begins the first time you meet with the patient.

        2. The Psychiatric Aide II continues to make observations about the patient.

            a. Those discussed at the beginning of class

            b. The patient's response to the interventions

        3. The observations are reported to the head nurse and recorded in the chart.

        4. The nurse will use these observations with his/hers to evaluate the plan of care.

        5. The treatment periodically reviews the goals and interventions, and:

            a. Notes which goals have been achieved

            b. Revises goals

            c. Sets new target dates

            d. Establishes new goals and interventions

IV. Summary and Conclusion

    A. Key parts of a measurable goal

    B. Reasons why it is important to develop individualized plans of care

    C. Steps in developing a plan of care

In this lesson, we have discussed the key parts of a measurable goal, reasons why it is important to develop an individualized plan of care, and the steps involved in developing the plan. It is important that all caregivers, especially psychiatric aides because they are with the patient 24 hours a day, follow the plan of care.

LESSON PLAN: 8

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT II : THE INDIVIDUALIZED TREATMENT PLANNING PROCESS

INFORMATION TOPIC: II-1

INTERACTION ITEMS:

1. What is meant by an individualized plan of care?
2. Why is it important to have individualized plans of care?
3. Why should a goal be measurable?
4. Why should the goal be written to reflect what the patient will do and not the staff?
5. What is meant by the term interventions?
6. Why should a goal have a target date for achievement?
7. Why is it important to identify the patient's strengths?
8. What is the Psychiatric Aide II's role in the development of the plan of care?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

1. Arrange for each student to sit in on a treatment team meeting in order to observe the development of the plan of care.
2. Have each student copy the plan of care (excluding the name) of the patient they have been assigned. As a class, evaluate the plans to see if the objectives are goal directed, measurable, and descriptive of what is expected of the patient. Also, have each student list the strengths and needs of his/her assigned patient.

LESSON PLAN: 9

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT II : THE INIDIVIDUALIZED TREATMENT PLANNING PROCESS

SCOPE OF UNIT:

This unit is designed to instruct the student about the individualized treatment planning process. Information will be given about how the plan of care is developed, the role of the Psychiatric Aide II in this process, how the Psychiatric Aide II will use the plan of care in his/her work, and how to chart in relation to the plan of care.

INFORMATION TOPIC: II-2 OR DEMONSTRATION: ______

PROVIDING NURSING CARE BASED ON THE INDIVIDUALIZED PLAN OF CARE

(Lesson Title)

LESSON OBJECTIVE - THE STUDENT SHOULD BE ABLE TO:

1. Identify six reasons why nursing care should be based upon the plan of care.
2. Identify three points to remember about assignment sheets.
3. Identify six steps to follow when planning your nursing actions from the plan of care.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Facility guidelines and policies about treatment plans and nursing care plans
2. Sample care plans from your facility
3. Facility assignment sheets

INFORMATIONAL ASSIGNMENT:

Have each student bring treatment and/or nursing care plan forms used in his/her facility.

REFERENCES: (Instructor's Additional Information)

Lewis, LuVerne Wolff. Fundamental Skills in Patient Care. 2nd ed., Philadelphia: J.B. Lippincott Co., 1980, pp. 78.

INTRODUCTION:

In the last lesson, we discussed how the plan of care is developed and why a plan of care is important. In this lesson, we will discuss how you can use the plan of care to plan the nursing care you will perform during a given shift. It is important to remember that the plan of care serves as a guide much like a road map to help you work in a certain direction. Without this guide, you may become lost and provide care in a haphazard manner or provide care that meets your needs rather than the patient's needs. Remember, the patient is our number one concern, so, use his/her plan of care as your guide for better nursing.

LESSON PLAN: 9

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT II: THE INDIVIDUALIZED TREATMENT PLANNING PROCESS

INFORMATION TOPIC: II-2

OUTLINE: (Key Points)

I. Reasons Why Nursing Care Should Be Based On the Plan of Care

   A. Provides continuity of care around all three shifts

   B. Individualizes patient care

   C. Nursing care is goal-directed toward assisting the patient change identified behavior.

   D. Guides the actions of all care givers

   E. Provides for an exchange of information among team members so that everyone is aware of what is being planned

   F. Increases alertness for making meaningful observations that will assist in the assessment of the patient's condition

II. Key Points to Remember About Assignment Sheets

   A. Forms that enable the care giver to make note of special assignments

   B. Enables you to plan, organize, and prioritize your work directly on the form

   C. Care giver can make notes on the assignment sheet about his/her response to:

      1. Nursing interventions

      2. Activities

      3. Medications

   D. Observations about patient behavior can be noted on the assignment sheet.

      1. Physical health

      2. Emotional health

        3. Improvement in behavior

        4. Lack of improvement

    E. Notes made on the assignment sheet will assist you in writing accurate, descriptive nursing notes.

III. Steps to Follow When Planning Your Nursing Actions From the Plan of Care

    A. Review the plan of care.

    B. Identify those aspects of care which you are qualified to perform.

    C. Make notes on your assignment sheet about your intended actions.

    D. Prioritize and schedule your work so that you spend the majority of your time with the patient rather than in the office.

    E. Perform your care.

    F. Observe and make written notes on the assignment sheet about the patient's response.

IV. Summary and Conclusion

    A. Reasons why nursing care should be based on the plan of care

    B. Key points to remember about assignment sheets

    C. Steps to follow when planning your nursing actions from the plan of care

In this lesson, we have discussed how to plan your nursing care from the care plan. The assignment sheet will be a helpful worksheet. Use it daily.

LESSON PLAN: 9

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT II : THE INDIVIDUALIZED TREATMENT PLANNING PROCESS

INFORMATION TOPIC: II-2

INTERACTION ITEMS:

1. Why is it important to follow the plan of care?
2. Why is an assignment sheet helpful?
3. How should you use the assignment sheet?
4. What are the suggested steps for planning your work based upon the plan of care?
5. Who makes and revises the plan of care?
6. Who fills out the assignment sheet?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

1. Ask the students to take the plan of care copied for the last lesson and plan the care they would perform for that person during a specific shift. Check to see that each student has followed the guidelines presented in class.
2. Review where the plan of care is located, i.e., in the chart or on the kardex.
3. If your facility holds nursing care conferences, hold one in class with instructors leading the conference. Have the students use the care plans they have copied and an assignment sheet.

LESSON PLAN: 10

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT II : THE INDIVIDUALIZED TREATMENT PLANNING PROCESS

SCOPE OF UNIT:

This unit is designed to instruct the student about the individualized treatment planning process. Information will be given about how the plan of care is developed, the role of the Psychiatric Aide II in this process, how the Psychiatric Aide II will use the plan of care in his/her work, and how to chart in relation to the plan of care.

INFORMATION TOPIC: II-3 OR DEMONSTRATION: ______

RECORDING OBSERVATIONS IN RELATION TO THE INDIVIDUALIZED PLAN OF CARE

(Lesson Title)

LESSON OBJECTIVES - THE STUDENT SHOULD BE ABLE TO:

1. Recall three key concepts of charting on medical records.
2. Identify four guidelines for charting in reference to the plan of care.
3. Complete according to facility guidelines four forms used by nursing service.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

INFORMATIONAL ASSIGNMENT: (Student)

REFERENCES: (Instructor's Additional Information)

INTRODUCTION:

In today's lesson, we will be reviewing the concepts of charting. As we have emphasized in the past, the patient is an individual who must receive individualized care in order to get better. In addition, this individualized care must be carefully documented. If we do not reflect in the charting that we attempted and did assist the patient in dealing with his/her specific problems, then, legally, it is assumed that no care was given. Careful documentation also lays the foundation for a more accurate and objective evaluation of the patient's progress. Finally, it enables us to have greater continuity of care over all three shifts. Hopefully, as a PA II you will realize the importance of accurate documentation, and act to serve as a role model for other psychiatric aides.

LESSON PLAN: 10

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT II : THE INDIVIDUALIZED TREATMENT PLANNING PROCESS

INFORMATION TOPIC: II-3

OUTLINE: (Key Points)

I. Key Concepts of Charting on Medical Records

  A. Review approved Standard Hospital abbreviations and symbols.

  B. Purpose of charting

    1. Communication

    2. Continuity of care

    3. Legal document

    4. Individualized treatment

  C. Basic rules and guidelines

    1. Notes must be precise and exact.

    2. Use correct span of shift as related to date.

    3. Do not skip lines.

    4. Use only approved abbreviations (see facility's policy).

    5. Complete proper headings on each chart sheet.

    6. Never erase. Draw one line through an error. Write error and initial.

    7. Use simple, correct terminology.

    8. Use direct quotes when describing an emotional state.

    9. Indicate number of times an event occurs during a shift, day, week, etc.

    10. Make follow-up notations of results of actions.

    11. Use correct grammar, spelling, and punctuation (use the dictionary).

12. Read notations made by other personnel.

13. Chart what you actually see and hear.

14. Signature (first name or initial, last name, job title)

15. Never chart a procedure before it has been performed.

16. All charting is done in ink.

II. Guidelines for Charting in Reference to the Plan of Care

A. Nursing notes should describe the patient's behavior in relation to a goal from the plan of care.

1. Enables team to evaluate more objectively progress toward accomplishment of goals

2. Provides permanent record of patient behavior in relation to specific problems

B. Must be written frequently enough to evaluate progress (Review facility guidelines on how frequently to chart.)

C. Follow the facility guidelines for charting information that does not relate to a specific treatment goal.

D. Information to include in the nursing note:

1. The goal number

2. Concise description of the patient's behavior - include direct quotes from the patient

3. Your nursing interventions

4. Patient's response to nursing interventions

III. Nursing Forms and Resources

A. Nursing service forms

1. Purpose of each

2. Procedure for completion

B. Reference resources

C. Library services

IV. Summary and Conclusion

A. Key concepts of charting on medical records

B. Guidelines for charting in reference to the plan of care

C. Nursing forms and resources

LESSON PLAN: 10

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT II : THE INDIVIDUALIZED TREATMENT PLANNING PROCESS

INFORMATION TOPIC: II-3

INTERACTION ITEMS: (Review Items)

1. What are the purposes of charting?
2. Why is it important to write concise and accurate nursing notes?
3. Why is it important to chart only what you actually see and hear?
4. Why is it important to chart in relation to a goal number?
5. What are your facility guidelines on charting?
6. How should you chart information that may not relate to a specific goal number?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

1. Have each student write a daily nursing note on an assigned patient. This nursing note should be evaluated daily by the instructor.
2. Ask the students to discuss situations that were difficult for them to describe in writing. Explore ways of describing the situation in writing.
3. Present a case study. Have each student write a nursing note on the case study in class. The instructor should evaluate each note.

UNITS I & II

TEST

True-False

In the space provided, place a "T" if the item is True or an "F" if the item is False.

__F__ 1. The environment in which you study has no bearing on your ability to learn.

__T__ 2. A good study habit is to underline important words, sentences, and phrases.

__F__ 3. A good time to study is just before a test.

__T__ 4. When selecting an answer to a test question, usually your first thought is correct.

__F__ 5. Assessing your current level of skills and knowledge is a waste of time because once a skill is learned it will never be forgotten.

__T__ 6. Assessing your current level of skills may provide you with an opportunity to recognize your areas of strength.

__T__ 7. An aggressive style of communication infringes upon the rights of others.

__F__ 8. A submissive style of communication is honest, direct, and the most productive.

__T__ 9. A satisfactory work environment is necessary for the mental health of the staff.

__T__ 10. Morale is affected by the physical condition of the work setting.

__F__ 11. Gossip is a way of showing genuine concern for coworkers.

__F__ 12. The Psychiatric Aide II is expected to teach the patient new job skills and assist him/her in relearning old ones.

__F__ 13. The Psychiatric Aide II is responsible for making patient assignments and evaluating the care that is given.

__T__ 14. A goal is always written in measurable terms.

__F__ 15. It is not necessary to set a target date for the accomplishment of a goal.

T 16. An individualized plan of care helps the patient know what he/she is working to accomplish.

T 17. Individualized patient care is specific to the patient's needs.

F 18. Assignment sheets are optional.

T 19. Following steps in planning your nursing actions will aid in setting priorities.

T 20. Writing nursing notes in relation to a treatment goal provides the treatment team with objective data for evaluating the patient's progress.

Matching

Match the following qualities of a psychiatric aide with their definitions. The answers may be used once, more than once, or not at all.

a. Charming
b. Confidential
c. Courteous
d. Dependable
e. Dignified
f. Poised
g. Negative attitude
h. Positive attitude

a 1. Ability to please others

f 2. Even tempered

d 3. Uses facility's procedure when absent

f 4. Remains even tempered and composed

h 5. Positive feelings about people, places, and things

c 6. Considers others

b 7. Does not discuss patient's welfare with friends

c 8. Introduces self to patient's family

d 9. Reports uncompleted assignments to charge personnel

g 10. Dislikes working with people

Match terminology with medical/legal problem.

a. Assault
b. Battery
c. Consent
d. Fake imprisonment
e. Invasion of privacy
f. Privileged communication

a 1. Ties patient in chair without an order

e 2. Unnecessary exposure of patient while preparing to assist with shower a 3. Tell a patient, "If you don't be quiet, I'll tie your hands down."

c 4. Patient decides to attend church services.

f 5. Discuss patient's diagnosis and treatment with a friend.

Multiple Choice

Circle the correct response.

1. A therapeutic work environment promotes:

   a. absenteeism.

   b. behavior problems.

   c. higher salaries.

   [✓ d.] job satisfaction.

2. People tend to communicate more effectively when:

   a. others are less critical.

   b. needs are met.

   [✓ c.] communication is clear and consistent.

   d. all of the above.

   e. none of the above.

3. Developing trusting relationships with coworkers depend upon:

   a. consistency in behavior.
   b. offering critical advice.
   c. examining ones attitudes and feelings.
   d. sharing with others confidential information.

      1. both a & b

      2. both b & c

      [✓ 3.] both a & c

      4. both a & b

4. It is important to plan and organize your work because it enables you to:

   a. work in a haphazardly manner.

   [✓ b.] see the whole picture and stay on course.

   c. push work aside and not accomplish tasks.

   d. identify those tasks that can be accomplished by the next shift.

5. Techniques for planning and organizing work involve:

   a. doing tasks as they arise.

   b. doing all easy tasks first.

   c. putting off as much as you can for the next shift.

   [✓ d.] setting priorities and scheduling your work throughout the shift.

6. The first step of the problem solving process is:

   a. act on the plan.

   [✓ b.] gather information.

   c. identify the problem.

   d. evaluate the results.

   e. develop a plan.

7. Reasons why nursing care is based on the plan of care are:

   a. provides continuity of care around all three shifts.
   b. nursing care is goal oriented.
   c. makes work more convenient for staff members.
   d. individualizes patient care.
   e. provides exchange of information among staff members.

      1. all of the above.

      2. none of the above.

      [✓ 3.] a, b, d, & e

      4. a, b, c, & d

8. Assignment sheets are necessary because:

   a. they serve as a legal record of the nursing care you gave.
   b. observations about patient can be noted on the assignment sheet.
   c. assists in writing nursing notes.
   d. provides the opportunity for making notes about special assignments.

      1. all of the above.

      2. a, b, & c

      [✓ 3.] b, c, & d

      4. none of the above.

9. The steps to follow when planning your nursing actions include:

   a. review the plan of care for the patients assigned to you.
   b. allow yourself plenty of free time for visiting with co-workers.
   c. make notations regarding patient observations you wish to make.
   d. identify those aspects of care you are qualified to perform.
   e. spend all of your time with the patient.

      [✓ 1.] a, c, & d

      2. b, d, & e

      3. a, d, & e

      4. c, d, & e

10. Which of the following is considered a role of the Psychiatric Aide II as a member of the interdisciplinary treatment team?

    a. Prescribe medications.

    b. Make plans for discharge.

    c. Coordinate the nursing care.

    [✓ d.] Observe, report, and record information about the patient's behavior.

11. Which of the following interdisciplinary team members would be responsible for psychological testing and interpretation?

    a. Physician

    b. Registered Nurse

    c. Psychiatric Social Worker

    [✓ d.] Psychologist

12. Which of the following is an objective of the Psychiatric Aide II course?

    a. Demonstrate basic skills and techniques in performing basic nursing procedures according to the program standards.

    b. Demonstrate beginning skills in communication and observation.

    c. Demonstrate beginning skills in forming and maintaining therapeutic aide-paient relationships.

    [✓ d.] Demonstrate advanced knowledge and technical skills in the care of the mentally ill patient.

13. You have overheard a co-worker telling a patient, "Shut up and be quiet or I'll make life miserable for you while you're on this ward!" What should you do? (Answer could vary according to the facility's policy.)

    [✓ a.] Report the incident in writing and verbally to your supervisor immediately. Record the date, time, circumstances surrounding the incident, and exactly what was said.

    b. Nothing. Talking to the patients this way helps to keep them in line.

    c. Nothing. The co-worker is really a "tough" person and may hurt you if you report him/her.

    d. Talk to the co-worker yourself and explain that talking to patients this way is not therapeutic.

14. Which one of the following is not considered a barrier that prevents communication?

    a. Changing the subject

    [✓ b.] Concentrating on what is being said and done

    c. Giving your opinion about the situation without being asked

    d. Belittling the other person's feelings

15. Which of the following are examples of nonverbal communication?

a. Facial expression
b. Gestures and body movement
c. Loud speech
d. Touch

1. a, b, & c

[✓ 2.] a, b, & d

3. b, c, & d

4. a, c, & d

LESSON PLAN: 11

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

SCOPE OF UNIT:

This unit is designed to provide the Psychiatric Aide II with current techniques and interventions in psychiatric nursing. It will include cultural aspects of behavior, the patient and his/her family, group therapy, current therapies, and specific patient behaviors that require interventions.

INFORMATION TOPIC: III-1 OR DEMONSTRATION: ______

UNDERSTANDING MENTAL HEALTH
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT SHOULD BE ABLE TO:

1. Differentiate between good mental health and poor mental health.
2. Recall five key concepts related to feelings.
3. Identify fourteen coping methods used by everyone.
4. Recall five key concepts related to individual strengths.
5. Recall five basic needs common to everyone.
6. Identify five consequences of basic needs not being met.
7. Identify the developmental stages.
8. Recall four key concepts related to the family life cycle.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Handout #1: Responses to Maladaptive Behavior
2. Handout #2: Coping Mechanisms

INFORMATIONAL ASSIGNEMENT: (Student)

Heimericks, Belinda. Psychiatric Aide I. Columbia, MO: Instructional Materials Laboratory, University of Missouri-Columbia, 1982, pp. 603-616 and 667-678b.

REFERENCES: (Instructor's Additional Information)

Haber, Judith, et al. Comprehensive Psychiatric Nursing. St. Louis, MO: McGraw-Hill Book Co., 1978, pp. 6, 33-34.

Miller, J.R. and Janosik, E. Family Focused Care. St. Louis, MO: McGraw-Hill Book, Inc., 1980, pp. 35-37.

INTRODUCTION:

When people are admitted to a hospital for treatment of a mental illness, we somehow think they are very different. Frequently they are stereotyped, labeled, and discriminated against. Yet we would never think of doing this to someone admitted for treatment of a physical illness. As mental health workers, it is our duty to dispel the myths surrounding mental illness and help people realize that people with a mental illness have the same needs and experience the same feelings as those who do not suffer from a mental illness. We must also remember that patients in mental hospitals are individuals and have strengths or assets that can be used to help them recover. It is up to us to look for these strengths and utilize them when working with the patients.

LESSON PLAN: 11

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-1

OUTLINE: (Key Points)

I. Differentiating Between Good Mental Health and Poor Mental Health

  A. Characteristic signs of good mental health

    1. Lives in harmony with self and others

    2. Expresses feelings in healthy ways.

    3. Successfully copes with problems

    4. Able to postpone the gratification of personal needs

  B. Characteristic Signs of Poor Mental Health

    1. Extremes in feelings

      a. Sadness

      b. Anxiety

      c. Elation, euphoria

    2. Little or no impluse control

    3. Does not live in harmony with self and others

    4. Expresses feelings in ways that are harmful to self and/or others

    5. Poor judgment

II. Key Concepts Related to Feelings

  A. Feelings common to everyone

    1. Love

    2. Joy

    3. Happiness

    4. Fear

    5. Anger

6. Sadness

7. Hurt

B. Feelings are experienced in varying degrees by all of us.

1. Feelings can be placed on a continuum.

2. Mentally ill people may experience an extreme amount or absence of feelings.

a. Depressed patient feels extremely sad

b. Withdrawn patient feels extremely anxious

c. Some severely withdrawn patients exhibit no emotion.

C. Feelings should not be ignored.

D. Children should be encouraged to express their feelings in socially acceptable ways.

1. Talking about their feelings

2. Utilizing physical exercise to relieve tension

E. People deal with strong feelings in many ways. (Review Handout #2: Coping Mechanisms, Psychiatric Aide II Manual, pp. 141-142.)

1. This is called coping.

2. Coping methods are healthy until used in extreme.

3. Everyone uses coping methods.

4. Coping methods are used to reduce tension.

III. Coping Methods Used by Everyone

A. Rationalization

B. Denial

C. Sublimation

D. Identification

E. Projection

F. Introjection

G. Repression

H. Suppression

I. Reaction formation

J. Isolation

K. Regression

L. Conversion

M. Displacement

N. Fantasy

IV. Key Concepts Related to Individual Strengths

A. Strengths are assets or positive aspects about the person.

B. Everyone has strengths.

C. Strengths can be used in helping the patient recover.

D. Strengths can be identified by talking with and observing the patient.

E. Examples of strengths

1. Education
2. Skills
3. Hobbies
4. Family/friends support system
5. Ability to perform activities of daily living (ADL)
6. Religion
7. Financial status
8. Past ability to cope with problems
9. Ability to verbalize feelings
10. Insight into problems
11. Ability to problem-solve
12. Ability to get along with others

V. Basic Needs Common to Everyone

A. Survival

B. Security

C. Love and belonging

D. Esteem and Recognition

E. Self-actualization

VI. Consequences of Needs Not Being Met

A. Tension results

B. Anxiety level rises

C. Energy focused on finding ways to satisfy needs

D. Behavior patterns may become maladaptive in an attempt to satisfy or cope with unmet needs (Review Handout #1.)

VII. Developmental Stages of the Individual

A. Period of infancy - Oral Stage - Trust vs. Mistrust (Birth to one year)

1. Central task - development of trust begins through experiences with care givers, i.e., mother

2. Resolution - the development of trust

3. Lack of resolution results in mistrust

4. Psychopathological and physical symptoms seem to have at least part of their origins during this time.

a. Alcoholism, drug abuse, compulsive eating, obesity, functional stomach distress, peptic ulcers.

b. Schizophrenia, withdrawal, paranoia

c. Manic-depressive or bipolar disorder

d. Neglected or abused children feel neglected, helpless in danger

e. Antisocial persons feel at odds with self and others

f. Infants separated from mothers or mother substitutes may **fail to thrive**.

B. Period of early childhood - Anal Stage Training Period - Autonomy vs. shame and doubt (1 yr. - 3 yrs.)

1. Central task - development of sense of autonomy

a. Realizes separateness from parents

b. Beginning of individuality

c. Recognizes power of control over environment

2. Resolution - the development of self-control along with self-esteem

3. Lack of resolution - lasting feelings of doubt and shame

    a. May over-manipulate others

    b. May become ritualistic and obsessed with repetition

C. Initiative vs. Guilt - Oedipal Period (3 yrs. - 6 yrs.)

1. Central task - develops a sense of initiative

2. Resolution - develops assertiveness without guilt; needs guidance, not punishment

3. Lack of resolution

    a. Development of feelings of guilt and anxiety which override personal goals

    b. As an adult, may be expressed as hysterical denial, over-compensation, or psychosomatic illness

D. Industry vs. Inferiority - Period of Latency (6 yrs.- 12 yrs.)

1. Central task - sense of accomplishment

2. Resolution - secure sense of abilities to work at age-appropriate tasks and to show competence in work

3. Lack of resolution - sense of inferiority and inadequacy; may accept work as an obligation and as criterion of worthwhileness, possibly resulting in conformist and/or workaholic

E. Identity vs. Role confusion - Adolescence (12 yrs. - ?)

1. Central Task - transition from childhood to adulthood

2. Resolution - establish self-identity and independence

3. Lack of resolution

    a. Role confusion with deep distressing feelings of doubt

    b. Possible delinquency or psychotic episodes

F. Intimacy vs. Isolation - Young Adulthood Period (21-45 yrs.)

1. Tasks

    a. Selecting a mate

    b. Careers

        c. Marriage, family, home

    2. Resolution

        a. Commitment to concrete affiliations and partnerships

        b. Ethical strengths

        c. Intimacy with significant others

        d. Significant professional relationships and friendships

        e. Competition and cooperation

    3. Lack of resolution - isolation and distance which may lead to serious character problems

G. Generativity vs. Stagnation (45-60 yrs.)

    1. Central task - accepts responsibility for what they are creating and/or producing and works toward guiding the next generation

    2. Resolution - experiences satisfaction from helping others and is able to form lasting relationships with others

    3. Lack of resolution - feeling of personal defeat which may result in stagnation and/or rebellion against family, friends, job

H. Integrity vs. Despair - Maturity (60yrs - old age)

    1. Central task - review of life accomplishments and acceptance of changing roles in family and society

    2. Resolution - wisdom, renunciation, maturity, acceptance

    3. Lack of resolution - depression and despair

VIII. Key Concepts Related to the Family Life Cycle

A. When individuals form a family, there are family developmental tasks to be accomplished.

    1. Each stage has critical events which necessitate a change in behavior and responsibilities of members

    2. Examples

        a. Marriage

        b. Birth of children

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        c. Launching children

        d. Death of member

B. Individuals must blend their personal ambitions and desires with the family members for harmonious relationships.

C. Family life cycle based on Duvall

1. Marital family
    a. Adjust to living with another person
    b. Begin the marriage
2. Child-bearing family (4½ yrs)
    a. Adjust to being parents
    b. Must establish a home
3. Pre-school family - nurture, guide, and direct children
4. School-age family
    a. Educate children
    b. Begin socialization of children
5. Teenage family
    a. Allowing children more freedom and independence
    b. Balance freedom with responsibility
6. Launching family
    a. Allow children to leave home
    b. Husband and wife find interests other than children
7. Middle-aged family
    a. Re-establish bonds between husband and wife
    b. Maintain family ties
8. Aging family
    a. Adjust to retirement
    b. Cope with death of relatives and friends.
    c. Cope with aging and loneliness

D. Loss of a family member adds stress to the family life cycle and results in changing roles and responsibilities for remaining members.

IX. Summary and Conclusion

A. Differentiating between good mental health and poor mental health

B. Key concepts related to feeling

C. Coping methods used by everyone

D. Key concepts related to individual strengths

E. Basic needs common to everyone

F. Consequences of needs not being met

G. Developmental Stages of the individual

H. Key concepts related to the family life cycle

In today's lesson, we have discussed signs of good mental health and poor mental health. We have also discussed feelings, ways of coping, and basic needs that everyone have, as well as how to identify individual strengths in others. It is important to remember that people with mental illness experience the same feelings and needs as people without mental illness.

LESSON PLAN: 11

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-1

INTERACTION ITEMS: (Review Items)

1. What are characteristics of good mental health?
2. What are characteristics of poor mental health?
3. List feelings common to everyone.
4. Why is it important to recognize that feelings are experienced by everyone?
5. Why is it important to look for strengths in patients?
6. How does one identify strengths in another?
7. Give examples of strengths.
8. What is the central task of each of the developmental stages of the individual?
9. What are the eight stages of the family life cycle?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

1. Discuss what mental illness means to the students, and how their feelings have changed since they began working in a hospital for the mentally ill.
2. Discuss how the students personally deal with feelings such as anxiety, anger, and fear. Relate this to their being role models for patients and PA I's.
3. Present case studies of several patients. Have the students identify the strengths of each patient. Discuss how the students arrived at their decisions.

Responses to Maladaptive Behavior - 22 Categories

Maladaptive Behavior	Response
A. Hostile and verbally abusive patients	1. Remain calm in face of abuse. 2. Refrain from arguing with or further provoking patient. 3. Help patient understand and express his/her feelings; find methods of coping with them. 4. Reassure, support, and calm. 5. Discourage hostile behavior without rejecting patient.
B. Agitated, hyperactive, destructive, and combative patients	1. Intervene immediately when patient needs controls or limits. 2. Approach patient in non-threatening manner; allow physical space. 3. Do not react emotionally. 4. Be firm but understanding; do not show fear. 5. Consistently enforce limits. 6. Do not argue or further provoke patient. 7. Attempt to discover cause for disturbance. 8. Help patient verbalize feelings and discuss problems. 9. Remove patient to nonstimulating, safe place. 10. Reassure, support, calm, and soothe 11. Provide appropriate diversion. 12. Provide appropriate physical activity. 13. Use judgment in applying or discontinuing restraints or seclusion. 14. Through actions reassure patient his/her behavior hasn't alienated staff members. 15. Encourage patient to understand, control, and accept responsibility for his/her own behavior. 16. Reinforce positive behavior.
C. Suicidal or self-abusive patients	1. Observe for signs of suicidal intent. 2. Respond to suicidal phone calls with immediate support. 3. Prevent patient from harming self. 4. Be warm and reassuring; offer support and external control. 5. Point out positive aspects of patient's life. 6. Recognize and do not reinforce inappropriate vices for attention.

Maladaptive Behavior	Response
D. Alcoholics and drug abusers	1. Maintain objective, accepting, non-condemning attitude. 2. Recognize signs of DT's or drug withdrawal and provide necessary physical care. 3. Calm and reassure patient. 4. Recognize signs if patient continues to drink or use drugs. 5. Search patient for drugs and alcohol. 6. Do not argue with intoxicated patient. 7. Firmly confront patient with games he/she is playing.
E. Patients who elope or want to leave treatment	1. Be alert for signs of pending elopement and take preventive actions. 2. Remain calm; avoid agitating patient. 3. Use proper precautions around locked area. 4. Divert patient's attention. 5. Set firm limits within patient's legal rights. 6. Encourage patient to continue therapy if needed. 7. Be concerned for patient's welfare. 8. Use good judgment in pursuing and returning patient. 9. Do not reinforce inappropriate bids for attention.
F. Uncooperative patients	1. Be aware of fears and try to alleviate them. 2. Explore feelings and reasons for attitudes. 3. Calmly give explanations. 4. Be patient and reassure; avoid threats and physical force. 5. Offer incentives. 6. Allow choices between alternatives. 7. Do not give in; firmly insist on cooperation. 8. Through actions, assure patient his/her behavior hasn't alienated staff members. 9. Accept isolated instances of uncooperativeness without over-reacting.
G. Patients who violate rules	1. Be composed. Assess offense and appropriateness of consequences. 2. Confront about violations and set firm limits. 3. Be sure rules are clear. 4. Use tact in pointing out violations.

Maladaptive Behavior	Response
H. Patients with insomnia, restlessness	1. Calm and reassure by talking and listening. 2. Move patient in order not to disturb others. 3. Arrange milieu conducive to sleep and rest. 4. Offer companionship, food, or quiet activities to restless patient.
I. Withdrawn or depressed patients.	1. Approach in non-aggressive manner. 2. Firmly get patient out of bed and into activities. 3. Show personal interest and encourage trust. 4. Help patient discuss and understand problems. 5. Help depressed to release underlying anger. 6. Encourage seeing positive aspects. 7. Encourage activities involving interaction and self-esteem.
J. Patients fighting/ arguing with, or irritating each other	1. Remain objective. 2. Point out behavior that offends others. 3. Help patients discuss feelings about each other. 4. Help patients resolve quarrels without violence. 5. Separate or distract quarreling patients if indicated.
K. Pesty, nagging, demanding patients	1. Control own irritation. 2. Teach appropriate methods to gain attention. 3. Confront with behavior and set limits. 4. Listen and try to give needed reassurances. 5. Arrange for frequent, brief contacts.
L. Tearful, distressed patients	1. Show concern and understanding. 2. Help patient express and accept feelings of distress. 3. Calm, support, and reassure.
M. Fearful, anxious, or worried patients	1. Help identify fears, anxieties, and worries. 2. Offer reassurance and encourage trust. 3. Be friendly but not aggressive. 4. Take action to allay patient's expressed fears.

Maladaptive Behavior	Response
N. Inappropriate, manipulative behavior	1. Ignore obvious attempt to irritate. 2. Consistently ignore giving desired response. 3. Set firm limits for patient who's "testing." 4. Confront with behavior.
O. Compulsive and ritualistic behavior	1. Help control compulsive behavior if indicated. 2. Encourage and support non-ritualistic activities.
P. Bizarre behavior	1. Respond as soon as patient needs controls. 2. Help patient understand and control behavior. 3. Avoid reinforcing bizarre behavior. 4. Reorient patient gently to reality.
Q. Inappropriate sexual behavior	1. Maintain non-condemning, accepting attitude. 2. Set firm limits. 3. Counsel and teach appropriate behavior.
R. Disoriented, confused, or incoherent patients	1. Give information and assistance as often as necessary. 2. Be patient; do not hurry patient. 3. Be kind and firm in helping patient behave appropriately. 4. Reality-oriented conversation and objects used.
S. Hallucinations	1. Remove from stimulating environment. 2. Be kind and concerned. 3. Focus patient on reality. 4. Calm patient by talking and listening.
T. Paranoid or delusional patients	1. Do not provoke, agitate, or argue. 2. Focus on reality; do not reinforce delusion. 3. Develop trusting relationship to lessen fear.
U. Patients who lie or steal	1. Confront and teach alternative behavior. 2. Use tact while confronting.
V. Poor hygiene or self-care	1. Use patience and repetition to form health routines. 2. Use rewards. 3. Kindly and firmly encourage patient to care for him/herself.

COPING MECHANISMS

1. **Sublimation**
   Changing of impulses or drives into socially accepted activities. Normal and successful process. Ex. - Strong sexual drives of adolescence directed into athletics or competitive sports

2. **Identification**
   Very early pattern of attaching to oneself certain qualities, emotions or behaviors associated with the personality of someone else. Influences growth of ego and formation of super-ego

3. **Projection**
   Attempts to get rid of undesirable thoughts, attitudes, traits and impulses (which are painful and objectionable) by attributing them to someone else. Ex. - "It's not my fault I failed the test. The teacher made it too hard."

4. **Introjection**
   Opposite of projection. Unconsciously takes into himself the image of another person with all the emotions and sentiments surrounding that person. (love or hate) Healthy if he makes a part of himself the advice, warnings and standards of parents. Unhealthy if hatred or agression is turned inward upon himself

5. **Repression**
   Where painful or unacceptable memories impulses or drives are pushed out of conscious into unconscious. (Much energy used for repression, less energy used and available for constructive thoughts)

6. **Supression**
   Intentionally and consciously controls feelings, impulses and behaviors he believes are threatening his welfare. Intentionally puts out of awareness but can readily be recalled. Ex. - "I refuse to think about it."

7. **Reaction Formation**
   Two conflicting elements. One that is acceptable is strenghtened while the other is repressed. Closely related to repression. Ex. - An agreeable, anxious to please person who never seems to get angry or disagree may be defending himself against feelings of rage, anger or resentment.

8. **Isolation**
   Separation of memory from emotion. Remembers the incident but isolates the emotion or feeling. Ex. - Can tell of a traumatic experience, as loss of loved one, but shows no feeling

9. **Regression**
   The ego gives up an advanced emotional level and goes back to an earlier stage of adjustment. Ex. - Older child starts wetting bed under emotional stress

10. **Conversion**
A mental conflict is converted into a physical symptom. Ex. - Soldier on way to battlefield is torn between desire to serve his country and belief it is wrong to kill, develops paralysis, blindness, deafness with no organic basis

11. **Displacement**
Reduces anxieties by transferring an emotion attached to one person, object, or situation. Ex. - Man irritated at boss, argues with wife, wife scolds child, child kicks cat

12. **Rationalization**
Unconscious justification, excuses or reasoning given to make behavior logical. Ex. - Man buys expensive car he can't afford. He justifies it on the basis 'my wife wanted it'

13. **Denial**
Unpleasant facts, thoughts, or actions treated as if they did not exist. Unconscious level not to be confused with lying. Ex. - Person told his mother has just died, acts as if he had not received the information and continues to talk and act as if she still lives

14. **Fantasy**
A kind of 'make believe' or 'day dreaming' where one attempts to cope with reality by imagination (normal in early childhood) Becomes a negative means of adjustment when it becomes a real substitute for action. Retreats more and more into a dream world

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LESSON PLAN: 12

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

SCOPE OF UNIT:

This unit is designed to provide the Psychiatric Aide II with current techniques and interventions in psychiatric nursing. It will include cultural aspects of behavior, the patient and his/her family, group therapy, current therapies, and specific patient behaviors that require interventions.

INFORMATION TOPIC: III-2 OR DEMONSTRATION: ______

UNDERSTANDING HOW CULTURE AFFECTS BEHAVIOR
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT SHOULD BE ABLE TO:

1. Identify ten cultures within the U.S. and seven ways they are bound together to form a system.
2. Identify four subgroups that maintain the values and traditions of culture.
3. Identify three reasons why it is important to be aware of cultural differences.
4. Identify three ways the Psychiatric Aide II can remain therapeutic with patients despite cultural differences.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

INFORMATIONAL ASSIGNMENT:

None

REFERENCES: (Instructor's Additional Information)

Haber, J., et al., Comprehensive Psychiatric Nursing. St. Louis: McGraw-Hill Book Co., 1978, pp. 18-30.

Pasquali, E A., et al., Mental Health Nursing: A Bio-Psycho-Cultural Approach. St. Louis: C.V. Mosby Company, 1981, pp. 35-67.

INTRODUCTION:

The United States is considered the melting pot of many cultures with various beliefs. Every caretaker and every patient is born into a culture and comes into the hospital setting with these cultural beliefs. In order to remain therapeutic and effective in our nursing care, we must be aware of how these cultural differences will influence the nursing care we provide and the health state of the patient.

LESSON PLAN: 12

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-2

OUTLINE: (Key Points)

I. The Multicultural United States

   A. Cultural groups are each a system bound together by:

      1. Values
      2. Traditions
      3. Beliefs
      4. Dress
      5. Food
      6. Norms or rules
      7. Language

   B. Various cultural groups

      1. British-Americans
      2. Afro-Americans
      3. Italian-Americans
      4. German-Americans
      5. Sino-Americans
      6. Irish-Americans
      7. Polish-Americans
      8. Mexican-Americans
      9. Rural Americans
      10. Urban and Suburban Americans

II. Traditions and Values of Cultures Maintained Through Various Subgroups

   A. Family

    1. Nuclear
    2. Extended
    3. Role relationships determined by the culture.
    4. Stress occurs when a family member attempts to change roles.

B. Neighborhood
    1. Group norms
    2. Conformity
    3. Support system
    4. Group identity
    5. Share common interests

C. Religion
    1. Powerful influence on families and communities
    2. Conflict can occur if religious values of a family member change.

D. Schools
    1. Children may be exposed to teachers from a different cultural background.
    2. Exposure may be beneficial but may also cause conflict.

III. Reasons To Be Aware of Cultural Differences

A. Definitions of abnormal and normal behavior are culturally bound. Acceptable behavior in one culture may be regarded as abnormal in another culture.

B. Caregivers are influenced by the culture in which they were raised.
    1. Can be compatible or in conflict with the patient's cultural beliefs.
    2. Caregivers must be aware of the influences their culture has in their daily lives.
    3. Cultural influences exhibited through our attitudes
        a. Innermost beliefs
        b. Largely unconscious

c. Displayed through verbal and nonverbal behavior

d. May be a source of conflict with others whose attitudes differ from ours.

C. Being admitted to the hospital is a cultural change for patients.

1. Terminology and equipment differ from what their home environment is.

2. Roles change

a. Independent to dependent role

b. Decision-making powers limited

c. Personal belongings limited

IV. Ways the Psychiatric Aide II Can Remain Therapeutic With Patients Despite Cultural Differences

A. Recognize own attitudes and beliefs.

B. Remain open-minded about other's beliefs.

C. Be aware of patient's background.

D. Allow the patient to retain decision-making abilities as much as possible.

V. Summary and Conclusion

A. The multicultural United States

B. Traditions and values of cultures maintained through various subgroups

C. Reasons to be aware of cultural differences

D. Ways the Psychiatric Aide II can remain therapeutic with patients despite cultural differences

In this lesson we have discussed how various cultural beliefs influence our behavior and how we interact with others. Hopefully, as a caregiver, you will remain alert to cultural differences and strive to remain open-minded about others.

LESSON PLAN: 12

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-2

INTERACTION ITEMS:

1. Do you believe people who suffer from mental illness are responsible for their behavior?
2. Do you believe they can change their behavior if they really want to?
3. Have your beliefs toward the mentally ill changed since you first started working in a psychiatric facility? If so, in what way? What do you attribute the change to?
4. Have you noticed certain cultural characteristics among patients you have worked with? If so, what are they?
5. How will being knowledgeable about cultural influences on behavior help you with your work?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

1. Assign each student to read about a specific culture and report on it in class.
2. Divide into two groups. Have one group list the characteristics of a rural community and its people, and the other group list the characteristics of a city community and its people. Compare and contrast these characteristics with the entire class. Discuss the implications for nursing care.
3. Identify the cultural influences within the community where you live.

LESSON PLAN: 13

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

SCOPE OF UNIT:

This unit is designed to provide the Psychiatric Aide II with current techniques and interventions in psychiatric nursing. It will include cultural aspects of behavior, the patient and his/her family, group therapy, current therapies, and specific patient behaviors that require interventions.

INFORMATION TOPIC: III-3 OR DEMONSTRATIONS: ______

THE PATIENTS AND THEIR FAMILIES
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT SHOULD BE ABLE TO:

1. Identify six ways the family influences the patient.
2. Identify five unhealthy roles that may be assigned a family member.
3. Identify five responses the family may have to the patient's illness and hospitalization.
4. Identify five ways that the Psychiatric Aide II can work effectively with the patient's family.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

INFORMATIONAL ASSIGNMENT:

Heimericks, Belinda. Psychiatric Aide I. Columbia, MO: Instructional Materials Laboratory, University of Missouri-Columbia, 1982, pp. 617-632.

REFERENCES: (Instructor's Additional Information)

Goldenberg, Irene and Goldenberg, Herbert. Family Therapy: An Overview. Monterey, CA: Brooks/Cole Publishing Company, 1980, pp. 48-71.

Haber, Judith, et al., Comprehensive Psychiatric Nursing. St. Louis: McGraw-Hill Book Company, 1980, pp. 161-176.

Pasquali, Elaine A. Mental Health Nursing: A Bio-Psycho-Cultural Approach. St. Louis: C. V. Mosby Company, 1981, pp. 234-237.

INTRODUCTION:

When the patient is admitted to the hospital, the family is in a state of crisis. Roles must be reassigned and new feelings toward the patient may emerge. The Psychiatric Aide II may be in a position to help the patient and family cope with the patient's illness and hospitalization.

LESSON PLAN: 13

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-3

OUTLINE: (Key Points)

I. Ways Family Influences Patient

   A. Values and beliefs of society are learned from the family.

   B. Communication patterns are learned from the family.

   C. Methods of coping with stress are learned from the family.

   D. Interpersonal skills are learned from the family.

   E. The child's identification is learned from within the family system.

   F. Personality and emotional health of the child are shaped by the family.

II. Various Roles That Family Members Play

   A. Healthy roles change as the family progresses through the family life cycles.

   B. Unhealthy roles are unconsciously assigned to members in an effort to relieve conflict and tension within the family.

      1. Scapegoat

      2. Clown

      3. Blacksheep

      4. Genius

      5. Sick person

   C. The patient may be the "identified" person with emotional problems when in actuality the entire family is in need of help.

III. Family's Response to the Patient's Illness and Hospitalization

   A. Upon hospitalization, the family is in a state of crisis.

B. Roles must be reassigned.

C. The family may alienate the patient.

D. Varied feelings may be experienced by the family.

  1. Relief
  2. Guilt
  3. Shame
  4. Pain

E. The patient and family may suffer from stereotyped views about mental illness from members of the community.

IV. The Psychiatric Aide's Role in Working Effectively With the Patient's Family.

A. Be courteous. You are in a public relations position.

B. See that the patient and family have privacy for visits.

C. Be available to the patient before and after family visits. The patient may need to ventilate.

D. Be patient. Because of a variety of reasons, the family may be critical of the care the patient is receiving.

E. Remember how culture may influence the family's behavior.

V. Summary and Conclusion

A. Ways family influences patient

B. Various roles that family members play

C. Family's response to the hospitalization

D. The Psychiatric Aide II's role in working with the patient's family

In this lesson we have discussed how the family has influenced the patient. We have also discussed ways in which thy Psychiatric Aide II can work effectively with the patient's family.

LESSON PLAN: 13

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-3

INTERACTION ITEMS:

1. Why is it important to discuss the patient and his/her family?
2. How do our families influence us as adults?
3. What is meant by the patient assuming the sick or scapegoat role?
4. How can you work effectively with the patient and family?
5. Discuss some of the stereotyped views toward mental illness.
6. Does the Psychiatric Aide II have a responsibility to change these stereotyped beliefs? If so, how can a Psychiatric Aide II do this?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

1. Ask the students to discuss families who have come to visit patients. Discuss the family's interaction patterns with the patient and the patient's behavior before and after their visit. How did the Psychiatric Aide II intervene, if he/she did?
2. Ask the students to describe a "difficult" family that they visited. Have the students or instructors role play the family. Have the instructor role play how to appropriately deal with the family. Have the instructor role play a discussion with the patient about his/her family's visit.

LESSON PLAN: 14

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

SCOPE OF UNIT:

This unit is designed to provide the Psychiatric Aide II with current techniques and interventions in psychiatric nursing. It will include cultural aspects of behavior, the patient and his/her family, group therapy, current therapies, and specific patient behaviors that require interventions.

INFORMATION TOPIC: III-4 OR DEMONSTRATION: ______

CURRENT THERAPIES USED IN TREATING THE MENTALLY ILL
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT SHOULD BE ABLE TO:

1. Identify three major philosophies to treatment.
2. Define the eight psychosocial therapies with the appropriate name of the therapy.
3. Identify three side effects and three nursing interventions of ECT treatment.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

INFORMATIONAL ASSIGNMENT: (Student)

Heimericks, Belinda. Psychiatric Aide I. Columbia, MO: Instructional Materials Laboratory, University of Missouri-Columbia, 1982, pp. 11-12.

REFERENCES: (Instructor's Additional Information)

Davison, Gerald C. and Neale, John M. Abnormal Psychology. 3rd ed., New York: John Wiley and Sons, Inc., 1982, pp. 35-66.

Haber, Judith, et al. Comprehensive Psychiatric Nursing. St. Louis: McGraw-Hill Book Company, 1978.

Pasquali, Elaine A., Alesi, Eleanor G., Arnold, Helen M., and DeBosis, Nancy. Mental Health Nursing: A Bio-Psycho-Cultural Approach. St. Louis: C.V. Mosby Company, 1981, pp. 209-249.

INTRODUCTION:

Although many believe a common-sense approach to dealing with people is therapeutic, it can hardly solve all the complicated problems our patients have. In fact, over the years, people have devoted a lifetime in trying to determine the causes of mental illness and the most effective treatments. This work has resulted in a variety of treatment approaches. As a Psychiatric Aide II, you will be expected to have some knowledge of these treatment approaches. In today's lesson, we will discuss these approaches and the rationale for them.

LESSON PLAN: 14

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-4

OUTLINE: (Key Points)

I. Three Major Philosophies of Treatment
  A. Psychoanalytic therapy
    1. Basic premises
      a. Mind is divided into three parts.
        1) Id
        2) Ego
        3) Super ego
      b. Anxiety is a result of intrapsychic conflict.
      c. Defense mechanisms protect the ego from anxiety.
        1) Repression
        2) Denial
        3) Projection
        4) Displacement
        5) Regression
        6) Rationalization
        7) Reaction formation
      d. Stages of development
        1) Oral
        2) Anal
        3) Phallic
        4) Latency
        5) Genital

    2. Therapy

        a. Free association - Verbalize whatever comes to mine.

        b. Dream analysis - Content of dreams is thought to be repressed material from the unconscious.

        c. Analysis of defenses - ego analysis

    3. Usually performed by psychiatrists

B. Behavioral therapy

    1. Basic premises

        a. Behavior can be learned by conditioning and reinforcement.

        b. Behavior can be changed through conditioning and reinforcement.

    2. Therapy

        a. Based on observing and determing what triggers the behavioral response

        b. Various therapeutic approaches

            1) Systematic desensitization

            2) Assertion training

            3) Aversive conditioning

            4) Token economy

            5) Modeling

            6) Role playing

            7) Cognitive restructuring (Rational Emotive therapy)

            8) Skills training

            9) Relaxation training

C. Humanistic approach

    1. Basic premises

        a. Believes the nature of humankind is basically good.

        - b. Mental illness develops when goodness is blocked. Goal of therapy is to get person in touch with true feelings.

    2. Therapy

        - a. Client centered
        - b. Unconditional positive regard - total and unconditional acceptance of the patient
        - c. Empathy
        - d. Reflection of patient's feelings
        - e. Once self confidence is developed, patient will listen to own feelings.

II. Psychosocial Therapies

A. Group therapy

1. An effective means of psychotherapy

    - a. Therapeutic meetings with specific goals
    - b. Five to ten members
    - c. Meets at least once weekly.
    - d. Reaches a group of people during a session rather than just one.

2. Various types of groups

    - a. Remotivation
    - b. Activities of daily living
    - c. Reality orientation
    - d. Transactional analysis
    - e. Groups for depression
    - f. Groups for alcoholism
    - g. Socialization skills
    - h. Intensive psychotherapy groups
    - i. Sensory-awareness

B. Individual Therapy

    1. Therapist meets regularly with patient to work on accomplishment of goals established by patient and therapist.

    2. Approach to treatment

        a. Psychoanalytic

        b. Behavioral

        c. Humanistic

        d. Eclectic - combination of any of the above approaches

C. Occupational therapy

    1. Rekindles old interests or develops new interests in hobbies, crafts, and/or job skills

    2. Raises self-esteem and self-confidence through accomplishments

    3. Assignment of task is based upon needs of individual.

        a. Release of anger.

            1. Pounding clay

            2. Weaving on loom

        b. Stimulate development of hobbies.

            1. Ceramics

            2. Woodworking

    4. Group therapy

        a. Activities of daily living

        b. Preparing to leave the hospital

        c. Controlling angry feelings

        d. Relaxation training

D. Recreational therapy

    1. Leisure time is an important part of being mentally healthy.

2. Provides patient with therapeutic leisure time while in hospital
3. Enables people to learn to work together cooperatively
4. Enables people to channel feelings through sports and games
5. Recreational therapy teaches the patient leisure activities that can be used at home.
6. Encourages interaction in a nonthreatening situation
7. Examples of recreational activities
    a. Bowling
    b. Swimming
    c. Dancing
    d. Playing cards
    e. Bingo

E. Dance therapy
    1. Can express self through nonverbal communications.
    2. Nonthreatening form of communication

F. Play therapy
    1. Utilized with children
    2. Children express themselves in nonthreatening situation through play.

G. Psychodrama
    1. Structured type of group psychotherapy
    2. Involves an acting out of emotions
    3. Provides added insight beyond what is achieved through verbalization
    4. Therapist takes a very active role in directing psychodrama sessions.

H. Family therapy

1. Examines communication patterns and relationships among family members

2. Can be conducted with the individual family, or family members can interact with other families in group therapy

3. The therapist clarifies communication patterns for the family and assists them in choosing more appropriate ways of relating.

4. Families may relate and communicate in unhealthy ways:

   a. Vagueness which leads to ambiguity

   b. Double-bind messages

   c. Myths or false beliefs

   d. Assign roles to family members such as scapegoat

5. Answering questions and communicating by "beating around the bush." No one is sure of what was said, which leads to confusion.

III. Electro-Convulsive Therapy (ECT or EST)

A. Procedure

1. Medication is given prior to ECT to dry up secretions and relax the patient.

2. Patient is anesthetized.

3. Two electrodes are placed on head.

4. Patient is shocked with a small amount of electrical current.

5. Followed by a seizure that may range in intensity from a toe twitching to a grand mal seizure.

6. Number of treatments may range from 5 to 30. Most physicians will not give more than 16.

B. Has been proven very effective for severe depression

C. Side effects

1. Memory loss and confusion

2. Light-headedness and drowsiness

3. Muscle aches and headache sometimes occur shortly after the treatment.

D. Nursing care:

1. Monitor vital signs.

2. Allow to rest.

3. Reorient to time, place, and person.

IV. Summary and Conclusion

A. Three major philosophies to treatment

B. Psychosocial therapies

C. Electro-Convulsive Therapy

In today's lesson, we have discussed the three major treatment philosophies being used. These philosophies are put into practice through individual and group therapy. The Psychiatric Aide II should have some awareness of these therapies in order to understand treatment approaches utilized in the facilities.

LESSON PLAN: 14

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-4

INTERACTION ITEMS:

1. What are the three major treatment philosophies?
2. How do they differ?
3. How does individual therapy differ from group therapy?
4. How does occupational therapy assist the patient with his/her problems? Recreation therapy?
5. Why is family therapy important in the treatment of patients?
6. What are some of the unhealthy ways families communicate and relate with one another?
7. Why is it important to be aware of these relationships and methods of communication?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

1. Have students observe or participate in one of the following:
    a. Recreation therapy
    b. Occupational therapy
    c. Group therapy
2. Examine the various treatment approaches and classify them according to following philosophies of treatment:
    a. Psychoanalytic
    b. Behavioral
    c. Humanistic

LESSON PLAN: 15

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

SCOPE OF UNIT:

This unit is designed to provide the Psychiatric Aide II with current techniques and interventions in psychiatric nursing. It will include cultural aspects of behavior, the patient and his/her family, group therapy, current therapies, and specific patient behaviors that require interventions.

INFORMATION TOPIC: III-5 OR DEMONSTRATION: ______

PSYCHOTROPIC MEDICATION THERAPY
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT SHOULD BE ABLE TO:

1. Identify one indication for antidepressant, antipsychotic, and antianxiety medications and lithium.
2. Identify five side effects for each of the four classifications - antidepressant, antipsychotic, and antianxiety medications and lithium.
3. Match the generic and trade name of the medication with the appropriate group.
4. Match the extra-pyramidal symptom with the appropriate category.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Handout #1: Examples of Antidepressant Medications
2. Handout #2: Interventions for Common Side Effects
3. Handout #3: Examples of Antipsychotic Medications
4. Handout #4: Examples of Antianxiety Medications
5. Handout #5: Extra-pyramidal Symptoms
6. Handout #6: Medication Worksheet

INFORMATIONAL ASSIGNMENT: (Student)

Handout #1: Examples of Antidepressant Medications

Handout #2: Interventions for Common Side Effects

Handout #3: Examples of Antipsychotic Medications

Handout #4: Examples of Antianxiety Medications

Handout #5: Extra-pyramidal Symptoms

REFERENCES: (Instructor's Additional Information)

DeGennars, Marion; Hymen, Robyn; Crannell, Alice M.; and Mansky, Peter A. "Psychotropic Drug Therapy," American Journal of Nursing. July, 1981, pp. 1303-1334.

Haber, Judith, et al. Comprehensive Psychiatric Nursing. St. Louis: McGraw-Hill Book Company, 1978, pp. 120-133.

Nurse's Guide to Drugs. Norsham, Pa.: Intermed Communications, Inc., Nursing 79 Books, 1979.

INTRODUCTION:

Medications are frequently used in the treatment of various psychiatric disorders. There are many medications on the market. Each medication belongs to a certain category and has a generic name as well as a trade name. Each medication has certain side effects. In today's lesson, we will look at four groups of medications - antidepressant, antipsychotic, antianxiety, and lithium, examples of specific medications in each group, side effects, and interventions for side effects. Although you will not be giving the medications, you will be expected to observe, report, and record the desired and untoward effects of the medication.

LESSON PLAN: 15

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-5

OUTLINE: (Key Points)

I. Antidepressant Medications

  A. Indication

    1. To relieve the symptoms of depression which include sadness, worthlessness, and helplessness

    2. May take effect within 2-4 weeks after starting the medication.

  B. Categories (See Handout #1.)

    1. Tricylics

    2. MAO Inhibitors

    3. Tetracyclics

  C. Common side effects (See Handout #2.)

    1. Dry mouth

    2. Constipation

    3. Urinary retention

    4. Delayed micturation

    5. Blurred vision

    6. Diaphoresis

    7. Tachycardia

    8. Orthostatic hypotension

    9. Anxiety, restlessness, and irritability

    10. Hypomania

    11. Mental confusion

    12. Drowsiness

        13. Increased likelihood for seizures
        14. Fine tremor and/or ataxia
        15. Weight gain
        16. Photosensitivity

II. Antipsychotic Medications

- A. Indication
    - 1. Used in the treatment of psychotic conditions
    - 2. Helpful in controlling the following symptoms:
        - a. Agitation
        - b. Emotional stress
        - c. Hallucinations
        - d. Delusions
        - e. Paranoia
        - f. Anxiety
        - g. Tension
        - h. Emotional withdrawal
        - i. Apprehension
- B. Categories (See Handout #3.)
    - 1. Phenothiazines
    - 2. Thioxanthenes
    - 3. Butyrophenones
    - 4. Dihydroindolones
    - 5. Dibenzoxapines
    - 6. Diphenylbutyl piperidines
- C. Common side effects - Usually are mild and disappear in a few weeks or with an adjustment in the dosage.
    - 1. Sedation
    - 2. Orthostatic hypotension and unstable blood pressure

3. Increased appetite
4. Weight gain
5. Increased likelihood for seizures
6. Dry mouth
7. Constipation
8. Nasal congestion
9. Blurred near vision
10. Delayed micturation
11. Rash
12. Jaundice
13. Skin pigmentation
14. Extra pyramidal symptoms (See Handout #5.)

D. Drugs that interact with antipsychotic medications

1. Alcohol
2. Barbiturates
3. Tricyclic antidepressants
4. Hydrochlorthiazide
5. Hydralazine
6. Guanethidine
7. Cigarettes
8. Meperidine
9. Anticonvulsants
10. Levodopa
11. General anesthesia

III. Antianxiety Medication

A. Indications

1. Relief of anxiety and tension, sleep disturbances, and symptomatic relief of acute alcohol withdrawal

    2. Sometimes referred to as minor tranquilizers or sedative-hypnotics

  B. Categories (See Handout #4.)

    1. Barbiturates (sedative-hypnotics)

    2. Nonbarbiturates (sedative-hypnotics)

    3. Antihistamines

  C. Common side effects

    1. Drowsiness

    2. Skin rash

    3. Photosensitivity

    4. Dizziness

    5. Slurred speech

    6. Jaundice

IV. Lithium Carbonate

  A. Indication: excessive mood elevation, extreme physical activity, and depression

  B. Therapeutic dosage

    1. Very narrow range of 0.5 - 1.5 MEq/L

    2. Must be monitored very carefully by taking regular blood samples.

    3. If the blood level is less than 0.5 MEq/L, there will be no effect.

    4. If above 1.5 MEq/L, the patient will show signs of toxicity.

    5. Lithium must be taken even though the patient may feel good and appear normal.

  C. Common side effects

    1. Mild - below 1.5 MEq/L

      a. Metallic taste

      b. Fine hand tremor

    c. Nausea
    d. Polyuria
    e. Polydipsia
    f. Diarrhea or loose stools
    g. Muscular weakness or fatigue

2. Moderate - 1.5 - 2.5 MEq/L
    a. Severe diarrhea
    b. Nausea and vomiting
    c. Mild to moderate ataxia
    d. Incoordination
    e. Dizziness
    f. Sluggishness
    g. Slurred speech
    h. Ringing of the ears
    i. Blurred vision
    j. Increasing tremor
    k. Muscle twitching

3. Toxicity - 2.5 - 7.0 MEq/L
    a. Cyclical movement or any movement of the eyeball
    b. Coarse tremor
    c. Difficulty in movement of the joints
    d. Visual or tactile hallucinations
    e. Oliguria or anuria
    f. Confusion
    g. Impaired consciousness
    h. Dyskinesia
    i. Grand mal seizures

        j. Coma

        k. Death

V. Medications Used to Treat Extra-pyramidal Symptoms

   A. Categories

      1. Anticholinergics

      2. Antihistamines

      3. Others

   B. Akathisia is best treated by reducing the dosage of the antipsychotic medication the patient is taking.

   C. Common side effects

      1. Skin rash

      2. Change in mood

      3. Constipation

      4. Nausea and vomiting

      5. Muscle weakness

VI. Summary and Conclusion

   A. Antidepressant medications

   B. Antipsychotic medications

   C. Antianxiety medication

   D. Lithium carbonate

   E. Medications used to treat extra-pyramidal symptoms

In this lesson, we have discussed the medications used in the treatment of patients suffering from mental illness. As you have probably noticed many of the side effects could apply to more than one medication. Your role, as a Psychiatric Aide II, is to be aware of the medications your assigned patients are taking, to be observant for therapeutic effects and side effects of the medications, and to report and record your observations.

LESSON PLAN: 15

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-5

INTERACTION ITEMS:

1. What are the indications for antidepressant medications? Antipsychotic medications? Antianxiety medications? Lithium?
2. What medications are given to treat extra-pyramidal symptoms?
3. What are common side effects of antidepressant medications? Antipsychotic medications? Antianxiety medications? Lithium?
4. What should you report and record about medications?
5. Which medication requires regular blood levels in order to maintain a therapeutic dosage?
6. What are extra-pyramidal symptoms?
7. When do they occur?
8. How are they treated?
9. What is the Psychiatric Aide II's role with regard to medication therapy?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

1. The instructor should demonstrate how to use the P.D.R.
2. Assign each student a number of psychotropic medications to look up in the P.D.R. during class. Ask the student to ascertain the indication, side effects, and contraindications of the medications.
3. Have the student look up each of the medications his/her patient is tâking. Have the student write down, to be handed in, the medication, classification, indications, and side effects of the medication.

Handout #1

EXAMPLES OF ANTIDEPRESSANT MEDICATIONS

Category	Generic Name	Trade Name
Tricyclics	Doxepin HCI	Adapin Sinequan
	Imipramine	Tofranil Janimine SK-Pramine Imavate Presamine
	Nortriptyline HCI	Pamelor Aventyl
	Desipramine HCI	Norpramin Pertofrane
	Amitriptyline HCI	Elavil Endep Amitril
	Protriptyline	Vivactil
	Trimipramine	Surmontil
Monoamine Oxidase Inhibitors (MAO Inhibitors)	Phenelzine Sulfate	Nardil
	Isocarboxazide	Marplan
	Tranylcypromine	Parnate
Tetracyclics	Maprotiline	Ludiomil

INTERVENTIONS FOR COMMON SIDE EFFECTS

Side Effect	Interventions
Anxiety, restlessness, irritability, confusion	Follow guidelines set forth for these type patient behaviors.
Constipation	Encourage fluids. Encourage more bran, fresh fruit, and vegetables to be eaten.
Diaphoresis	Encourage fluids.
Dizziness	Change positions slowly. Encourage caution when going up and down stairs. Have patient dangle feet over the edge of the bed a few minutes when first getting out of bed. Have patient sit down or lie down at first sign of dizziness. Record blood pressure when sitting and standing.
Dry mouth	Encourage frequent sips of water. Suggest sucking on hard, sour candy (sugarless) or ice chips, or chewing sugarless gum. Suggest swabbing the mouth with lemon-glycerin swabs. Encourage to brush teeth regularly.
Increased likelihood of seizures	Monitor for seizures and follow guidelines established for caring for the patient with seizures.
Tachycardia	Monitor pulse for rate and irregularities.
Urinary retention and delayed micturation	Monitor fluid intake and output.
Weight gain	Encourage to eat a well-balanced diet with minimal high calorie snacks.

Handout #3

EXAMPLES OF ANTIPSYCHOTIC MEDICATIONS

Category	Generic Name	Trade Name
Phenotiazines	Chlorpromazine	Thorazine Chlorprom Chlorpromanyl Chlorzine Klorazine Largactil Promachlor Sonazine Thoradex
	Triflupromazine	Vesprin
	Acetaphenazine	Tindal
	Butaperazine	Repaise
	Carphenazine	Proketazine
	Fluphenazine HCI	Prolixin Moditem HCI
	Fluphenazine Decanoate	Prolixin Decanoate Modecate Decanoate
	Fluphenazine Enanthate	Moditem Enanthate Prolixin Enanthate
	Perphenazine	Phenazine Trilafon
	Trifluoperazine	Clinazene Novoflurazine Pentazine Solazine Stelazine Terfluzine Trifluoper-Ez-Ets Triflurin Tripazine

Handout #3
(cont.)

Category	Generic Name	Trade Name
Thioxanthenes	Chlorprothixene	Taractan Tarasan
	Thiothixene	Navane
Butyrophenones	Haloperidol	Haldol
Dihydroindolones	Molindone	Lidone Moban
Dibenzoxapines	Loxapine	Daxolin Loxapac Loxitane Loxitane-C

EXAMPLES OF ANTIANXIETY MEDICATIONS

Category	Classification	Generic Name	Trade Name
Barbiturates	Sedative-hypnotics	Amobarbital and Amobarbital sodium	Amytal Isobec Amytal sodium
		Barbital and Barbital sodium	Buta-barb Butisol Day-barb Medarsed Neo-barb BBS Butal Butazem Buticaps Sarisol No. 1
		Pentobarbital and Pentobarbital sodium	Nebralin Maso-Pent Nembutal Gradumet Nembutal Sodium Nova-Rectal Penital Pentogen
		Phenobarbital and Phenobarbital sodium	Barbipil Barbita Eskabarb Gardenal Henomint Hypnette Luminal Mediphen

Handout #4

Category	Classification	Generic Name	Trade Name
			Orprine PBR 12 Pheno-Squar Solfoton Solu-barb Stental Luminal sodium
		Secobarbital and Secobarbital sodium	Seconal Seco-8 Secogen Sodium Seconal sodium Seral
Nonbarbiturates	Benzodiazepines	Chlordiazepoxide	A-poxide Chlordiazachel Corax C-Tran Dymopoxide J-Liberty Lebritabs Librium and others
		Chlorazepate	Tranxene
		Diazepam	D-Tran E-Pam Erital Meval Neo-Calme Novadipam Paxel

Handout #4 (cont.)

Category	Classification	Generic Name	Trade Name
		Chloral hydrate	Aquachloral Suprettes Chloralvan Cohidrate Felsules Noctec Novochlorhydrate Oradate
		Triolofos	Triclos
		Paraldehyde	Paral
		Hydroxyzine	Atarax Vistaril
Antihistamines		Dyshenhydramine	Allerdryl Baramine Bax Benadryl and others
		Promethazine	Phenacen-50 Phenergan Promethazine Provigan and others

Category	Classification	Generic Name	Trade Name
			Serenack Stress-Pam Valium Vival
		Flurazapem	Dalmane
		Lorazepam	Ativan
		Oxazepam	Serax
		Prazepam	Vestran
	Nonbenzodiazepines	Meprobamate	Equanil
		Tybamate	Tybatran Solacen
		Methaqualone and Methaqualone HCI	Quaalude Sopor Hyptor Parest Parest 400 Sedalone Somnafac Optimil
		Ethchlorvynol	Placidyl
		Glutelhimide	Doriden Rolathimide
		Methyprylon	Noludar

Handout #5

EXTRA-PYRAMIDAL SYMPTOMS

Categories of EPS	Symptoms
PARKINSONISM	Akinesia - fatigue - lack of interest - slowness - heaviness - lack of drive or ambition - vague bodily discomfort Muscular rigidity - "lead-pipe" rigidity - "cog-wheel" rigidity Stooped posture Shuffling gait Hypersalivation and drooling Tremor Masklike faces Loss of associated movements - lack of arm swing
DYSKINESIAS	Coordinated, involuntary, stereotyped, rhythmic movements of the limbs and trunk.
DYSTONIAS	Uncoordinated, bizarre, jerking, or spastic movements of the neck, face, eyes, torso, arm and leg muscles. Oculogyric crisis - backward rolling of the eyes Torticollis - sideways twisting of the neck Protrusion of the tongue Spasms of the back muscles (Symptoms are frightening and painful.)
AKATHESIA	Restlessness and agitation Unable to lie down or sit still

Categories of EPS	Symptoms
AKATHESIA (cont.)	Has difficulty sitting still to read, watch television or a movie, or do handwork such as knitting. May experience feelings of terror, fright, anger, or rage.
TARDIVE DYSKINESIA	Coordinated, rhythmic, stereotyped, abnormal, involuntary sucking, chewing, licking, and pursing movements of the tongue and mouth. Grimacing, blinking, frowning Tongue protrusion Rocking

MEDICATIONS USED TO TREAT EPS

Category	Generic Name	Trade Name
Anticholinergics	Benztropine mesylate	Cogentin
	Biperidine HCI	Akineton
	Cycrimine HCI	Pagitane HCI
	Ethopropazine HCI	Parsidol Parsitan
	Procyclidine HCI	Kemadrin Procyclid
	Trihexyphenidyle HCI	Aparkane Artane Hexaphen Novohexidyl and others
Antihistamine	Chlorphenoxamine HCI	Phenoxene
	Diphenhydramine HCI	Benadryl and others
	Orphenadrine HCI	Disipal
Others	Amantadine HCI	Symmetrel

Medication Worksheet

Medication	Classification	Indications	Side Effects

Handout #6

Medication Worksheet

Medication	Classification	Indications	Side Effects

Handout #6
(cont.)

LESSON PLAN: 16

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

SCOPE OF UNIT:

This unit is designed to provide the Psychiatric Aide II with current techniques and interventions in psychiatric nursing. It will include cultural aspects of behavior, the patient and his/her family, group therapy, current therapies, and specific patient behaviors that require interventions.

INFORMATION TOPIC: III-6 OR DEMONSTRATION: ______

THE PSYCHIATRIC AIDE II - RESPONSIBILITY IN SUPPORT GROUPS
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT SHOULD BE ABLE TO:

1. Identify six advantages of support groups.
2. Recall eight roles of the group leader.
3. Identify five points to remember when preparing for the group.
4. Identify nine guidelines for effective groups.
5. Identify the three phases of a group.
6. Identify four types of groups.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Handout #1: Reality Orientation Board
2. Handout #2: Guide for Reality Orientation

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INFORMATIONAL ASSIGNMENT: (Student)

Handout #1: Reality Orientation Board

Handout #2: Guide for Reality Orientation

REFERENCES: (Instructor's Additional Information)

Haber, Judith, et al. Comprehensive Psychiatric Nursing. St. Louis: McGraw-Hill Book Company, 1980, pp. 145-160.

Pasquali, Elaine A. Mental Health Nursing: A Bio-Psycho-Cultural Approach. St. Louis: C.V. Mosby Company, 1981, pp. 218-299.

INTRODUCTION:

Support groups are an effective means for treating patients and can be used for a number of topics. They are very effective in assisting individuals to stay in touch with reality and in developing interests in their environment. The Psychiatric Aide II can function in the role of co-leader with professionals of various disciplines in support groups designed for skill building and remotivation. Today's lesson will discuss group dynamics and the Psychiatric Aide II's responsibility in support groups.

LESSON PLAN: 16

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-6

OUTLINE: (Key Points)

I. Advantages of Support Groups
    A. Modeling of relating interpersonally with one another
    B. Opportunity to try out new behaviors in secure setting
    C. Support from group members
        1. Increases self-esteem of self and others
        2. Imparts knowledge of past experiences and successful ways of coping
        3. Increases insight into behaviors
    D. Instills hope
    E. Effectively communicates a message to more than one person at a time
    F. Chance to verbalize

II. Role of the Group Leader
    A. Facilitates and directs
    B. Responds to meaning and feelings of group members
    C. Keeps group reality oriented
    D. Accepts group at their level of functioning
    E. Remains empathetic
    F. Self-discloses in therapeutic manner
    G. Encourages group members to talk without monopolizing the conversation
    H. Keeps own personal opinions to a minimum

III. Points to Remember When Preparing for the Group

A. Selection of members

1. Appropriate members

a. The attention span should be long enough to sit in group.

b. The member should not be mute, deaf, nor have any severe mental impairments that would prevent them from participating. Exception: Reality Orientation group members would be selected because of severe mental impairment.

c. It is better to have a mixture of members who are verbal as well as those who are less verbal.

2. Number of members

a. Seven group members are ideal.

b. Four members are minimum.

c. Ten members are maximum.

3. Members should be interviewed prior to the first group meeting.

B. Select time, place, and days.

1. Time

a. Start on time.

b. Terminate the group at the scheduled time.

c. Choose time when members are not tired, hungry, or distracted by other events.

2. Always inform members of changes in scheduling.

3. Do not cancel unless for an emergency or less than four members are in attendence.

4. Group room should be well lighted, set at a comfortable temperature, and filled with comfortable chairs.

C. Group meetings can last up to one and a half hours.

1. Length of time depends on attention span of members.

2. Group members generally begin to feel comfortable after 45 minutes.

        3. Some groups may last only 30 minutes.

    D. Frequency of group meetings

        1. Two to three times a week

            a. Acute care setting

            b. Remotivation

            c. Reality orientation (ideally every day)

        2. One time weekly

            a. Some intensive therapy groups

            b. Long-term care setting

    E. Seating arrangement

        1. Circle

        2. Group leaders should not sit together.

        3. Group leaders change seats each session.

IV. Guidelines for Effective Groups

    A. Create a secure, comfortable atmosphere.

    B. Remain focused on the "here and now."

    C. Protect the self-esteem of all group members.

    D. Point out positive changes in group members.

    E. Be sensitive to the needs of group members, particularly of new members.

    F. Use laughter wisely.

        1. Can help to relax group members.

        2. Excessive use of laughter can slow the group's progress.

    G. Reinforce confidentiality of group by members as well as leaders.

    H. Encourage cohesiveness or group belongingness.

    I. Prepare group members for any changes in group in advance.

        1. Addition or loss of members
        2. Change in leaders
        3. Change in scheduling

V. Phases of a Group

- A. Orientation phase
    1. Establish rules and group norms.
    2. Testing of therapist
- B. Cohesive or working phase
    1. Sense of belongingness develops.
    2. Concern for other group members occurs.
- C. Termination phase
    1. Begins during first group session
    2. Feelings of group ending are dealt with.

VI. Types of Groups

- A. Remotivation
    1. Designed to rehabilitate patients who suffer from breakdown in socialization skills
    2. Stimulates interests outside themselves and promotes the relationship between leader and patients in a setting other than the normal unit setting
    3. Group discussions center around many topics.
        - a. Current issues
        - b. Customs and traditions of members
        - c. Food likes and dislikes
        - d. Any topic of interest to the groups
    4. Is very reality oriented; concerned with the "here and now."
    5. Should promote the restoration of function.
- B. Activities of daily living

    1. Can be broken down into several different kinds of groups dealing with ADL
        a. Personal hygiene
        b. Nutrition
        c. Money management
        d. Maintaining your home
        e. Social skills
    2. Designed to limit the effects of institutionalization as well as prepare patient for leaving the hospital

C. Reality Orientation (See Handout #1 and #2.)

D. Ward government
    1. Staff share responsibility of unit functioning with the patients.
    2. Patient leaders are elected by the patients.
    3. These leaders conduct the meetings and, along with the patients, establish unit rules and consequences for failure to follow rules.
    4. Assists the patients in:
        a. Accepting responsibility for self and others
        b. Participating in hospital life in democratic manner
        c. Retaining decision making powers and control over self
        d. Increasing their feelings of independence, socialization, and self-direction
    5. Meetings are held one to two times a week and last about 1-1 1/2 hours.

E. Other types of groups that would be led by a mental health professional
    1. Play therapy
    2. Intensive therapy
    3. Encounter groups

    4. Transactional analysis

    5. Medication education

    6. Other appropriate groups

VII. Summary and Conclusion

  A. Advantages of group therapy

  B. Role of the group leader

  C. Points to remember when preparing for the group

  D. Guidelines for effective groups

  E. Phases of a group

  F. Types of groups

In this lesson, we have discussed the responsibility of a Psychiatric Aide II in support groups. We have also discussed preparing for the group, techniques for an effective group, phases a group works through, and types of groups. Now you are ready to role play and observe actual groups.

LESSON PLAN: 16

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-6

INTERACTION ITEMS:

1. What are the advantages of support groups over individual therapy?

2. What is the role of the group leader?

3. What kinds of patients are best suited for a Reality Orientation group? Remotivation group?

4. What should the group leader do when preparing for a group?

5. What are the guidelines for conducting an effective group?

6. Why is it necessary to reinforce confidentiality in groups?

7. Why is it necessary to prepare members for any changes within the group, for example, the addition of new members?

8. What are the phases of a group and how will group behavior change during these phases?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

1. Observe various kinds of groups.

2. Role play a remotivation, reality orientation, and/or activities of daily living group. The instructor should function as the group leader. Discuss their feelings as group members and what could have been done differently to facilitate the therapy session.

Handout #1

Reality Orientation Board

A board with general information posted on it about that particular day, i.e., day, date, place, may be used as part of the learning environment for reality orientation.

Information that is written for a patient to read is most effective when the lettering is clear and large, when the words are in the language best understood by the patient, when the reading surface is without glare from lights, and when the information is at the patient's eye level. Reality orientation information is useful only when it is current.

Today is ______________________________

The date is ______________________________

The year is ______________________________

The city is ______________________________

The place is ______________________________

The next meal is ______________________________

We will eat at ______________________________

GUIDE FOR REALITY ORIENTATION

I. General Information

What is reality orientation? What does reality mean? What does orient mean? Reality means "that which has objective existence and is not merely an idea. Orient means" east and to put (especially oneself) into correct position or relation; to acquaint (especially oneself) with the existing situation." In other words, this means knowing who you are, where you are, who the people are around you, and having some idea of time (month, year, day of week, etc.).

Reality orientation, therefore, is a phase of rehabilitation. The philosophy of the staff of any facility is that each individual patient should make the maximum use of his/her assets and that no one is hopelessly mentally ill. The best use of the patient's abilities is made when rehabilitation is begun as soon as possible. Patients who need reality orientation are found in all age groups; however, a majority are found in the geriatric group.

The type of patient for whom this program is most appropriate is one who is confused or disoriented from any cause. He/she may have a moderate to severe degree of organic cerebral deficit resulting from arteriosclerosis. He/she may have had a head injury or a stroke. He/she may have a diagnosis of organic brain syndrome. His/her confusion may be a result of sensory deprivation or over medication.

The patient's first symptoms of confusion may accompany a physical illness; or he/she may gradually become absent-minded, forget common facts, or wander aimlessly. These symptoms often go untreated until they are severe. His/her family may express their concern that he/she is "not himself/herself." Accentuating the downhill process in some patients is an accompanying decrease in sight and hearing.

It is the task of the staff to reverse the downhill process. Besides treating the confusion, physical disabilities must also be treated. An attempt is made to correct impairments of hearing, sight, locomotion, speech, etc. Reality orientation begins by assisting the patient to use that portion of his/her cerebral function that is still intact.

Consistency of approach is the key to the rehabilitation of the confused patient. To achieve this consistency of treatment, the team approach has been found to be an effective means of communication. Attitude therapy, consisting of five basic attitudes, is an adjunct to this approach. An attitude is prescribed by the team for each patient. Usually active friendliness is the primary attitude used with the geriatric patient. This is the supportive ego-building attitude that helps the patient to feel that he/she is worth something after all, that someone cares, and that life has not passed him/her by. Often a matter-of-fact attitude is prescribed in conjunction with active friendliness, according to the behavior the patient is exhibiting. The rationale is that the patient should learn to accept some responsibility for his/her own behavior.

The matter-of-fact attitude prevents staff from doing for the patient those things he/she can do for himself/herself and influences him/her toward more positive self care. Other attitudes may be prescribed by the team, depending on the behavior the patient is exhibiting. Consistency in the use of attitudes is essential to the effectiveness of the treatment program. Each person who comes in contact with the patient must use the same attitude.

The reorientation to reality goes on during waking hours around the clock; the patient is constantly reminded of who he/she is, where he/she is, why he/she is here, and what we expect. This is 24-hour reality orientation. In addition, there are specific classes in reorientation. These are divided into two parts: a basic class and an advanced class. The classroom sessions are used to enhance learning in small groups in an educational setting.

The structured intensive reality orientation classes are carried out in a reality orientation classroom in designated areas. Basic and advanced classes are conducted on a regularly scheduled basis with nursing personnel conducting classes. For patients unable to attend regular classes, a modified program will include the use of reality orientation boards, calendars, clocks, etc. Either basic or advanced reality orientation classes will be prescribed by the treatment team on an individual basis. Progression from basic to advanced classes will be determined by daily observation and progress reports by personnel working directly with the patients. Some patients may reach advanced classes while others remain in the basic class for long periods. Assignment may vary considerably with patients, depending on their condition and their response.

The reality orientation program will be continued 24 hours a day with an intensive one-half hour of classroom orientation daily, five days a week, for either basic or advanced classes in the reality orientation classroom. The classes will be limited to one to five patients at a time depending on the condition of the patients. The instructor for the intensive one-half hour sessions should be the same from day to day, for a period of a minimum of two weeks.

The therapeutic atmosphere should be friendly, quiet, and secure in which all conversation and activities are reality oriented.

II. Points to Remember

A. Speak slowly and distinctly because many times older patients are hard of hearing.

B. Speak in a friendly manner, but do not talk to the patient as though he/she were a child.

C. Look directly at the patient when addressing him/her.

D. Maintain a calm, friendly approach.

E. Give the patient adequate time to respond.

The instructors are encouraged to use their own ingenuity and flexibility in conducting the classes. Reality orientation is more than telling. It is showing and providing for the patient to be active in the process. The key is conversation and/or activities which are short, simple, and focused on one point at a time.

More often an attitude of friendliness (active or passive) will be used for reality orientation patients. The treatment team prescribes any one or a combination of attitudes. Usually it is safe to use active friendliness, but always be alert to the patient's behavior and do not maintain this attitude if he/she becomes uncomfortable with your closeness. Move to passive friendliness if necessary.

Regular observation notes will be made to indicate progress in reality orientation classes.

The therapeutic atmosphere should be friendly, quiet, and secure in which all conversation and activities are reality oriented.

III. Twenty-Four Hour Reality Orientation

The orientation process is in effect 24 hours a day. Basic, current, and personal information is presented over and over to the patient, beginning with his/her name, where he/she is, and the date. Each contact the staff has with a patient will be utilized to improve awareness of person, time, and place. A patient should be told where he/she is going, the occasion, and what is expected of him/her. For example: "It's time to go to the classroom for lessons, Mr. Smith." "Today we want you to read the board." "Mr. Johnson, you go to eat your lunch at 12 o'clock every day." "It is time to take a nap, Mr. Jones. This is your bed. See, it has your name on it - John Jones." Continue to reward patient for his/her successes in finding his/her way around by praising the patient or giving the patient other appropriate rewards.

Suggested approaches: Be patient. Show respect by always addressing him/her as "Mr./Mrs." Repeat directions often. It may sound like a record to you but not to the patient. "Mr. Jones, this is Monday and it is time for your bath." "The bathroom is this way," as you accompany him to the bathroom. Continue this procedure until he knows where the bathroom is and when to take a bath. Utilize this type approach in similar situations such as going to bed, to meals, to the toilet, or any activities. Provide large calendars for the unit and small billfold sizes for each patient. Continue to encourage, but gradually decrease direct assistance when he is able to be more self-directing.

IV. Basic Reality Orientation classes

The basic reality orientation classes will meet five days a week for 30 minutes each day. No more than five patients will be included in one class. The instructor will find the following outline helpful in conducting the class.

A. Learning names

1. Introduce yourself.
2. Repeat your name if necessary.
3. You may ask the patient to repeat your name.
4. Be sure that he/she can pronounce it.
5. Always call the patient by his/her name and encourage him/her to call others by their names.

B. Activities

1. Provide simple activities such as identifying pictures, reading the reality orientation board, and writing his/her name.

2. Make use of the reality orientation board, the blackboard and felt board, teaching machines, film strip projector, and any other appropriate teaching aids.
3. Have the patient read, or repeat after instructor, information which is presented. (e.g., the menu for the next meal)
4. Move to more complex activities after patient improves sufficiently.

C. Suggested classroom procedure

1. Begin each session with a review of basic information.
2. If patient is unable to give the desired response, the instructor may tell him/her the answer and ask him/her to repeat it or write it.
3. If patient is unable to write his/her name, he/she may be able to spell it with anagrams.
4. Reward the patient immediately when he/she responds correctly. Say "good," "that's right," "fine," etc.
5. A large clock mock-up may be useful. The clock may be set for the time of the meeting. If the patient can read the time, give him/her immediate reinforcement--" good." Say, "that's good, it is now ___________ o'clock. This group meets every day at this time." At the end of the session, reset the clock and say, "What time is it now? Our meetings end at ___________ o'clock every day."
6. It is important to remember that these patients have short attention spans. If a patient does not make the correct response, tell him/her immediately and ask him/her to repeat it before you move on.
7. If the patient seems aware of the basic information, then he/she should be asked about such things as the name of his/her home town, his/her family, or his/her former occupation. The instructor must have correct information regarding these questions so he/she can supply the answer if the patient is in doubt.
8. Patients are often frustrated when they are not able to remember simple facts. Help to decrease his/her frustrations by asking him/her questions about things which he/she can answer.
9. The activity that is provided in the class is not the most important thing. The activity should be an easy, familiar one; but it should also lend itself to simple, friendly conversation. It probably will be the friendly and familiar communication that will rebuild self-confidence and restore dignity for the patient.

10. The activities we use in reorienting the patient are simple. Identification of familiar objects, picture recognition, word pictures, matching, and repetition of simple information form the basis of the program.
11. Do not expect too much from patients in reality orientation at first. Establish an attainable goal. Use praise, small rewards, special recognition, and reinforcement immediately for greatest effectiveness.

V. Advanced Reality Orientation

Advanced reality orientation classes are for those who have completed the basic classes or who are less confused. The same procedures that are used in the advanced classes. The patients will be expected to read and copy the reality orientation and the material listed on the blackboard. They will be given other materials to read and other projects to complete as selected by the class instructor. Spelling, writing, and simple arithmetic problems are used. Other activities may include: fill-in-the-blank quizzes, reading and discussing current events, using individual calendars, fill in the days of the month using audio-visual aids and discussing and using flash cards for identification of items. Any information of interest to the group could be used for discussion. Words should be kept simple and close to the reality situation. Emphasis should still be placed on days of the week, months, time, and place. Names of instructor and patients are given at every session.

VI. Graduation

When several patients have completed advanced reality orientation, a graduation exercise is held. Invitations are issued to staff members, patients, and family members of the graduating group. A tea table is prepared and decorated. Punch and cookies are served. The facility administrator, medical director, or team leader is asked to present each patient individually with a diploma. The diploma, inscribed with the patient's name and date of graduation, states that the patient has completed the prescribed course in reality orientation and is signed by the hospital director. Pictures are taken of the patients receiving their diplomas and are given to the patients.

After graduation the patients are included in educational therapy classes and remotivation sessions.

VII. The Family

The patient's family is included in the total treatment program from the day of admission to the day of discharge. The members of the family are taught to be "reality oriented" toward the patient and not to agree with his/her disoriented statements but to keep giving him/her reality information. Frequent visits are encouraged.

Before discharge, plans are made with the family for short trips home or trips to restaurants, stores, etc. Family members are included in the discharge plans. After discharge, they may call at any time for help from the staff. Reality orientation goes with the patient from health care facility to home.

LESSON PLAN: 17

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

SCOPE OF UNIT:

This unit is designed to provide the Psychiatric Aide II with current techniques and interventions in psychiatric nursing. It will include cultural aspects of behavior, the patient and his/her family, group therapy, current therapies, and specific patient behaviors that require interventions.

INFORMATION TOPIC: III-7 OR DEMONSTRATION: ______

THERAPEUTIC MILIEU
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT SHOULD BE ABLE TO:

1. Define therapeutic milieu.
2. Identify the purpose and seven characteristics of therapeutic milieu.
3. Recall seven attitudes that are essential for milieu to be therapeutic.
4. Identify five characteristic feelings of the emotional climate.
5. Identify five characteristics of the physical environment.
6. Recall eleven roles the nurse has in therapeutic milieu.
7. Recall seven roles the Psychiatric Aide II has in therapeutic milieu.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

INFORMATIONAL ASSIGNMENT:

Heimericks, Belinda. Psychiatric Aide I. Columbia, MO: Instructional Materials Laboratory, University of Missouri-Columbia, 1982, pp. 603-643.

REFERENCES: (Instructor's Additional Information)

Haber, Judith, et al. Comprehensive Psychiatric Nursing. St. Louis: McGraw-Hill Book Company, 1978, pp. 141-144.

Pasquali, Elaine A., et al. Mental Health Nursing: A Bio-Psycho-Cultural Approach. St. Louis: C.V. Mosby Company, 1981, pp. 210-218.

INTRODUCTION:

Milieu therapy has proven to be very successful in changing patient behavior through a structured environment. It requires a concentrated team effort of which the Psychiatric Aide II is an important team member. In today's lesson, we will discuss in depth what therapeutic milieu is and your role in implementing milieu therapy.

LESSON PLAN: 17

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-7

OUTLINE: (Key Points)

I. Definition, Purpose, and Characteristics of Therapeutic Milieu

  A. Manipulation of the environment for the purpose of minimizing symptomatic behavior and learning more appropriate psychosocial skills

  B. Purpose

    1. Prepare patient for successful re-entry into the community.

    2. Identify and discuss current style of communicating and relating with others.

    3. Learn more socially acceptable ways of communicating and relating with others.

    4. Identify and discuss current methods of coping.

    5. Learn more appropriate methods of coping.

    6. Practice new skills within established limits.

    7. Maintain and/or increase current level of independence.

  C. Characterized by:

    1. Active patient involvement in the planning and implementation stages. Patient accepts responsibility based on individual level of functioning.

    2. Treatment team actively involved with the patients

    3. Staff-patient, patient-patient relationships that are emotionally satisfying

    4. A reduction in psychological conflicts

    5. Community government or ward government meetings

a. Allows the patient to try new roles

b. Fosters group identification

c. Makes the patient accept greater responsibility for own behavior

d. Encourages the patient to be more aware and respectful of other people's needs

e. Practice making decisions as an individual and a group.

f. Practice problem solving as an individual and a group.

6. Limit setting

a. Degree of limits is determined by the type of patient being treated and the severity of his/her illness.

b. Patient and staff responsibilities are identified.

7. Includes a variety of therapies such as:

a. Group therapy

b. Individual therapy

c. Occupational therapy

d. Recreational therapy

II. Attitudes That Are Essential for Milieu to Be Therapeutic

A. Acceptance of the patient as a person with individual needs

B. Respect for the patient as a human being

C. Genuine concern for the patient and meaning what you say to him/her

D. Friendliness that is outwardly displayed toward the patient

E. Kind firmness

F. Watchfulness

G. Confidentiality

III. Characteristic Feelings of the Emotional Climate

- A. Warmth
- B. Friendliness
- C. Acceptance of the individual and not necessarily the behavior
- D. Optimism - You must believe that behavior can change.
- E. Security
  - 1. The patient needs to feel safe and protected.
  - 2. This can be accomplished through limit setting.

IV. Characteristics of the Physical Environment

- A. Home-like setting
- B. Attractively decorated
- C. Comfortable furniture arranged to promote conversation.
- D. Bedrooms that sleep no more than four people
- E. Furniture and closet space for keeping personal possessions away from others

V. The Nurse's Role in Therapeutic Milieu

- A. Setting the stage for therapeutic milieu by displaying attitudes that promote milieu therapy
- B. Coordinates nursing care
- C. Assesses patient behavior
- D. Sets limits on patient behavior
- E. Assesses physical symptoms
- F. Supervises the unit
- G. Frequently assists the patient-leader in conducting the patient government meetings
- H. Models appropriate communication skills and coping methods
- I. Acts as an interpreter for the patient and other members of the treatment team

J. Provides comfort measures for the patients

K. Administers medications

VI. The Psychiatric Aide II's Role in Therapeutic Milieu

A. Observes, reports, and records patient behavior

1. Provides data to the nurse

2. Data aids the nurse in the assessment process.

B. Models appropriate behavior by demonstrating appropriate ways of dealing with the following:

1. Happiness

2. Anger

3. Disappointment

4. Frustration

5. Initiates conversation with people he/she does not know

6. Is courteous to visitors

7. Is assertive, not aggressive

C. Assists the nurse in seeing that the unit maintains a home-like environment

1. Respects the unit as the patients' temporary home

2. Keeps the furniture arranged so that it promotes socialization

D. Implements limits established by the treatment team

E. Assists the nurse in providing comfort measures to patients

F. Is available to patients to talk, take on walk and engage in activities.

G. Assists the patient in problem-solving and decision-making.

VII. Summary and Conclusion

A. Definition, purpose, and characteristics of therapeutic milieu

B. Attitudes that are essential for milieu to be therapeutic

C. Characteristic feelings of the emotional climate

D. Characteristics of the physical environment

E. The nurse's role in therapeutic milieu

F. The Psychiatric Aide II's role in therapeutic milieu

In today's lesson, we have discussed therapeutic milieu and your role in seeing that therapeutic milieu is successfully implemented on the unit. Remember, it takes a team effort to institute and maintain a therapeutic milieu and you are an important member of the team!

LESSON PLAN: 17

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-7

INTERACTION ITEMS:

1. Why is it more important to establish a therapeutic milieu with a variety of therapies rather than to focus on one particular therapy such as individual therapy?
2. Describe in your own words what milieu therapy is.
3. How may milieu therapy differ from one group of patients to another such as long-term patients with schizophrenia versus antisocial patients?
4. What is your role as a Psychiatric Aide II in milieu therapy?
5. How does your role differ from the nurse's role?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

1. Assign the students to observe the milieu therapy on various units in the hospital. Have them take notes on the following and report to the class:
   a. Physical environment
   b. Emotional climate
   c. Nurse's role
   d. Psychiatric Aide II's role
   e. Limits, rules, regulations observed
   f. Therapies utilized
   g. Changes they would make for the milieu
2. Have the students break up into small groups and ask them to design a therapeutic milieu for different patient groups such as chronically ill patients, antisocial patients, adolescent patients, or geriatric patients. Discuss their designs with the class.

LESSON PLAN: 18

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

SCOPE OF UNIT:

This unit is designed to provide the Psychiatric Aide II with current techniques and interventions in psychiatric nursing. It will include cultural aspects of behavior, the patient and his/her family, group therapy, current therapies, and specific patient behaviors that require interventions.

INFORMATION TOPIC: III-8 OR DEMONSTRATION: ________

DEVELOPING A THERAPEUTIC AIDE-PATIENT RELATIONSHIP
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT SHOULD BE ABLE TO:

1. Identify four key concepts of a therapeutic aide-patient relationship.
2. Identify three stages of a relationship.
3. Identify four attitudes that are essential to a therapeutic relationship.
4. Identify eight techniques for establishing a therapeutic relationship.
5. Identify four skills to assist the Psychiatric Aide II in developing a therapeutic relationship.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

INFORMATIONAL ASSIGNMENT: (Student)

Heimericks, Belinda. Psychiatric Aide I. Columbia, MO: Instructional Materials Laboratory, University of Missouri-Columbia, 1982, pp. 603-643.

REFERENCES: (Instructor's Additional Information)

Carkhuff, Robert R. and Anthony, William A. The Skills of Helping. Amherst, Mass.: Human Resource Development Press, Inc., 1979, pp. 31-91.

Haber, Judith, et al. Comprehensive Psychiatric Nursing. St. Louis: McGraw-Hill Book Co., 1978, pp. 71-97.

INTRODUCTION:

The ability to establish a therapeutic relationship with patients is an essential skill for a Psychiatric Aide II. The therapeutic relationship is a planned, purposeful relationship based on skills that help people. It is not a social relationship and it is more than a common sense approach to working with people. In today's lesson, we will discuss the component parts of a therapeutic relationship as well as techniques, skills and attitudes for developing a therapeutic relationship.

LESSON PLAN: 18

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-8

OUTLINE: (Key Points)

I. Key Concepts of a Therapeutic Aide-Patient Relationship

  A. It is a purposeful interaction.

    1. It is a helping relationship.

    2. The aide is concerned with the patient's behavior.

    3. The patient is concerned with improving his/her behavior.

    4. The aide is aware of his/her feelings.

    5. The aide is aware of his/her strengths and utilizes them in helping the patient change behavior.

  B. It is characterized by empathetic understanding.

    1. The aide has a vested interest in the patient improving, but is not emotionally involved.

    2. The aide remains objective.

  C. It is an organized series of steps established by the patient and treatment team for the purpose of accomplishing specific goals.

  D. It is not a social relationship, in which:

    1. There is not a purposeful interaction.

    2. Both people are emotionally involved.

    3. Both people are seeking to satisfy their own personal needs.

II. Stages of a Relationship

  A. Orientation stage

    1. Begin developing trust.

2. The Psychiatric Aide II defines his/her role.

a. When he/she will be on duty

b. How he/she will help the patient

c. What the Psychiatric Aide II expects from the patient

3. Begin to establish goals that are in keeping with the treatment plan.

a. Psychiatric Aide II reports and records this information.

b. It assists the nurse and team in assessing patient behavior.

4. Termination begins with the first meeting by informing the patient of how long the relationship is expected to last.

B. Working stage

1. Goals have been established and are being worked on.

2. Patient behavior is observed in respect to goals.

3. New goals are established.

4. Present goals are evaluated.

5. Trust has been established.

6. Termination continues.

C. Termination phase

1. Patient is encouraged to discuss feelings about relationship ending.

2. Psychiatric Aide II may see patient regress to behavior exhibited in orientation stage.

3. This is patient's way of coping with the relationship ending.

III. Attitudes That Are Essential to a Therapeutic Relationship

A. Empathy

1. Remains objective but is in touch with the patient's needs and feelings.

  - 2. Differs from sympathy
    - a. Loss of objectivity
    - b. Identification with the patient
- B. Genuineness
  - 1. Truly concerned about patient's welfare
  - 2. Say and do what you really mean.
- C. Respect
  - 1. For the patient as a human being with individual needs
  - 2. Acceptance of him/her as a person - not necessarily of the behavior
- D. Honesty
  - 1. Truthfulness is essential.
  - 2. Lying to the patient will destroy any trust established.

IV. Techniques for Establishing a Therapeutic Relationship

- A. Always be consistent.
- B. Be available when the patient needs you.
- C. Discuss the patient's problems, not yours.
- D. Be patient.
- E. Offer reassurance but not false hope.
- F. Be a model of mental health.
- G. Treat the patient as you would want to be treated.
- H. Be aware of the cultural background of the patient.

V. Skills to Assist in Developing a Therapeutic Relationship

- A. Set the stage for interaction.
  - 1. Let the patient know you are available.
  - 2. Choose a quiet, comfortable setting, free of interruption, for talking.

B. Position yourself appropriately for the conversation.

1. Sit directly opposite the patient.
2. Sit with both feet flat on the floor.
3. Lean slightly forward.
4. Keep hands, feet, and legs still.
5. Make eye contact with the patient.

   (NOTE: The overly-suspicious patient may feel threatened by too frequent eye contact.)

6. This position communicates to the patient that he/she has your undivided attention.

   (NOTE: Sit slightly to the side of the suspicious patient. If the patient is uncomfortable and seems to feel threatened by your presence, terminate the interaction session for the present time.)

C. Observe

1. Body build
2. Posture
3. Appearance
4. Gestures and mannerisms
5. Focus of eyes
6. Nonverbal expressions

D. Listen with all of your senses.

1. Content - practice repeating word for word short phrases spoken by someone.
2. Respond by summarizing and clarifying.

   a. "You feel ____________?"

   b. "You mean ____________?"

   c. "So you're saying that ___________."

3. Listen for:

   a. Tone of voice

   b. Rapidity of speech

   c. Volume of speech

VI. Summary and Conclusion

- A. Key concepts of therapeutic aide-patient relationship
- B. Stages of a relationship
- C. Attitudes that are essential to a therapeutic relationship
- D. Techniques for establishing a therapeutic relationship
- E. Skills to assist the Psychiatric Aide II in developing a therapeutic relationship

In today's lesson we have discussed in-depth components of the therapeutic relationship and techniques for developing a helping relationship. It is essential for the Psychiatric Aide II to be able to establish therapeutic relationships with the patients if he/she is to be successful as a psychiatric aide.

LESSON PLAN: 18

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-8

INTERACTION ITEMS:

1. What is a therapeutic relationship?
2. What is a social relationship?
3. How do attitudes influence the development of relationships?
4. Why is it important to be aware of the cultural background of the patient you are working with?
5. Why is it important to understand the stages of a relationship?
6. Why is it important to begin termination with the first meeting?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

1. Have the students work in pairs with one being the aide and the other the patient and practice sitting in the recommended position and talking for 2-3 minutes about a hypothetical problem the patient has. The pair should reverse roles and repeat the exercise. Afterwards, the patient should tell the aide how comfortable he/she felt with the aide's techniques, observed strength, and areas for improvement. This exercise should not be done in front of the entire group. The pairs can be working at the same time.
2. Assign the student to a patient in the clinical area. Ask the student to keep an ongoing written record of the skills and techniques used to develop a therapeutic relationship, identify the stage of the relationship, and the feelings experienced by the Psychiatric Aide II.

UNIT III

TEST I

True-False

In the space provided, place a "T" if the item is True of an "F" if the item is False.

__T__ 1. ECT is the most effective in the treatment of depression.

__F__ 2. Muscle aches and headaches are never side effects of ECT.

__F__ 3. The personality and emotional health of the child is shaped only by the environment.

__T__ 4. The family and patient may suffer from stereotyped views about mental illness from members of the community in which they lived.

__F__ 5. Support from group members decreases self-esteem.

__F__ 6. An effective group leader monopolizes the conversation.

__T__ 7. Support groups provide the opportunity for patients to try out new behaviors.

__T__ 8. Therapeutic milieu is manipulation of the environment for the purpose of decreasing symptomatic behavior and learning more appropriate psychosocial skills.

__T__ 9. Acceptance of a patient as a person with individual needs is a necessary attitude for therapeutic milieu.

__F__ 10. Nursing service can maintain a therapeutic milieu without the assistance of the other members of the interdisciplinary team.

Completion

In the space provided, place an "H" for those items which are healthy roles assigned to family members and a "U" for those items which are unhealthy roles assigned to family members.

__U__ 1. Sick person

__U__ 2. Genius

__U__ 3. Clown

__U__ 4. Blacksheep

__U__ 5. Scapegoat

In the space provided, place a checkmark (✓) by the item which identifies those feelings experienced by family members when another member becomes mentally ill and requires hospitalization.

✓ 1. Relief

____ 2. Happiness

✓ 3. Guilt

____ 4. Pride

✓ 5. Pain

In the space provided, place a "G" by the item that characterizes good mental health and a "P" by the item that characterizes poor mental health.

G 1. Lives in harmony with others

P 2. Experiences extremes in feelings

G 3. Successfully copes with problems

G 4. Able to postpone the gratification of personal needs

P 5. Expresses feelings in ways that are harmful to self and others

In the space provided, place a checkmark (✓) by the item that correctly identifies the actions and/or attitudes a Psychiatric Aide II should take with the patient's family.

✓ 1. Be courteous

____ 2. Be cheerful

✓ 3. Provide privacy for visits

____ 4. Provide entertainment

✓ 5. Be available

Multiple Choice

Circle the correct response.

1. Which of the following is not one of the three phases of a group?

    a. Orientation

    b. Working

    [✓ c.] Learning

    d. Termination

2. The purpose of therapeutic milieu is to:

a. reduce the number of staff required.

b. teach patients how to keep the wards clean.

[✓ c.] prepare patients for re-entry into the community.

d. teach the patient marketable job skills.

3. Which of the following classifications of medications is given to relieve feelings of extreme sadness, worthlessness, and helplessness?

[✓ a.] Antidepressant medications

b. Antipsychotic medications

c. Antianxiety medications

d. Lithium carbonate

4. Which of the following classifications of medications is given to control hallucinations, delusions, emotional withdrawal, and paranoia?

a. Antidepressant medications

[✓ b.] Antipsychotic medications

c. Antianxiety medications

d. Lithium carbonate

5. Common side effects of antipsychotic medications include:

a. dry mouth.
b. photosensitivity.
c. jaundice.
d. hypotension.

[✓ 1.] All of the above

2. None of the above

3. a only

4. a & d

6. The treatment philosophy characterized by free association and dream analysis is:

a. humanistic.
[✓ b.] psychoanalytic.
c. behavioral.
d. group.

7. Basic needs which are not satisfied result in:

a. a very happy person.
[✓ b.] tension and anxiety.
c. an ability to tolerate frustration.
d. energy directed toward doing a good job at work.

8. Individual strengths can be identified in the following areas:

a. relationships with others.
b. self-care abilities.
c. education.
d. hobbies.
[✓ e.] all of the above.
f. none of the above.

9. Which therapy is a form of nonverbal communication that allows free expression through dance?

a. Milieu therapy
b. Music therapy
c. Psychodrama
[✓ d.] Dance therapy

10. The name of the developmental stage for the person aged 6-12 years is:

[✓ a.] Industry.
b. Oedipal.
c. Generativity.
d. Oral.

Matching

Match the trade name with the correct classification. Answers may be used more than once.

_b_ 1. Tofranil
_a_ 2. Chlorpromazine
_c_ 3. Valium
_a_ 4. Mellaril
_d_ 5. Cogentin

a. Antipsychotic
b. Antidepressant
c. Antianxiety
d. Anticholinergic

Match the extra-pyramidal catagory with its symptoms.

_c_ 1. Muscular rigidty, shuffling gait, tremors
_a_ 2. Coordinated, involuntary, stereotyped movements of the limbs or trunk
_d_ 3. Uncoordinated, bizarre, jerking or spastic movements of the neck, face, and/or eyes
_b_ 4. Restlessness and agitation, unable to sit quietly or recline
_e_ 5. Grimacing, blinking, frowning, tongue protrusion

a. Dyskinesias
b. Akathesia
c. Parkinsonism
d. Dystonias
e. Tardive dyskinesia

LESSON PLAN: 19

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

SCOPE OF UNIT:

This unit is designed to provide the Psychiatric Aide II with current techniques and interventions in psychiatric nursing. It will include cultural aspects of behavior, the patient and his/her family, group therapy, current therapies, and specific patient behaviors that require interventions.

INFORMATION TOPIC: III-9 OR DEMONSTRATION: ______

THE PATIENT WHO COPES BY WITHDRAWING FROM REALITY
(Lesson Title)

LESSON OBJECTIVE - THE STUDENT SHOULD BE ABLE TO:

1. Identify four key concepts related to the patient who copes by withdrawing from reality.
2. Recall ten common signs and symptoms of the person who copes by withdrawing from reality.
3. Recall ten nursing interventions for the patient who copes by withdrawing from reality.
4. Demonstrate in the clinical how to give nursing care as outlined on the plan of care to an assigned patient who copes by withdrawing from reality.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Handout #1: Nursing Interventions

INFORMATIONAL ASSIGNMENT: (Student)

Heimericks, Belinda. Psychiatric Aide I. Columbia, MO: Instructional Materials Laboratory, University of Missouri-Columbia, 1982, pp. 645-654b.

REFERENCES: (Instructor's Additional Information)

Pasquali, Elaine A., et al. Mental Health Nursing: A Bio-Psycho-Cultural Approach. St. Louis: C.V. Mosby Company, 1981, pp. 503-560.

INTRODUCTION:

About half of all beds in mental hospitals are used by patients who cope by withdrawing from reality. This serious mental illness is comparable to receiving a diagnosis of cancer. No one knows what causes it and there are a number of strategies used to treat it. As a Psychiatric Aide II, you job will be to establish a relationship with this patient. This patient is shy, sensitive and tends to remain alone. A psychiatrist once said that the best thing an aide could do for this patient is "be a friend". In this lesson, we will discuss this illness and interventions that will assist you in establishing a trusting relationship.

LESSON PLAN: 19

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-9

OUTLINE: (Key Points)

I. Key Concepts Related to the Patient Who Copes by Withdrawal

  A. Commonly referred to as schizophrenia

    1. Encompasses a variety of symptoms

    2. Has been inappropriately used to describe multiple personalities

    3. Patients with this diagnosis tend to live up to their diagnosis.

  B. Nursing's focus is on the patient and his/her behavior rather than the diagnosis of schizophrenia.

    1. Promotes individualized care

    2. Does not label the patient

    3. Patient does not have to live up to the label.

  C. The most serious of all mental illnesses

    1. Least understood

    2. Many theories are suggested about the cause.

    3. Many therapies are used in treatment.

    4. Found in all cultures throughout history

  D. The patient experiences severe anxiety.

    1. Copes by withdrawing

    2. Coping mechanisms fail.

    3. Most severe response to anxiety

II. Common Signs and Symptoms of the Person Who Copes by Withdrawal from Reality

  A. Tends to remain alone and aloof

B. Low self-esteem

C. Fear of rejection

D. Shy and sensitive

E. Affect or emotional response is lacking.

    1. Bland or dull

    2. Possibly no emotional response occurs

    3. Possibly inappropriate in that the patient may laugh when should be crying

F. Judgment is poor.

G. Difficulty in establishing satisfactory relationships with others

H. Very distrustful of others

I. Thought processes may be interrupted.

    1. Flight of ideas

    2. Blocking of thoughts

    3. Exhibits very concrete thoughts rather than abstract

J. May have delusions or false beliefs

    1. Worthlessness and guilt

    2. Others control his/her thoughts.

    3. Others rob him/her of thoughts.

    4. Others put thoughts in his/her mind.

K. May have hallucinations

    1. Most commonly auditory

    2. Visual hallucinations are usually drug induced.

L. Has difficulty separating the real world from fantasy

M. Can regress to point of totally neglecting activities of daily living

    1. Personal hygiene

    2. Nutrition

III. Nursing Interventions

A. Gain the patient's trust.
   1. Be consistent.
   2. Be honest.
   3. Be direct and concise when speaking.
   4. Speak in a moderately loud tone of voice.

B. Praise the patient for positive behavior.

C. Remember to treat the patient as a person first, by exhibiting nonjudgmental acceptance of him/her.

D. Encourage the patient to participate in unit activities.

E. Do not become defensive if the patient is verbally hostile towards you.
   1. You may be viewed as less threatening than whoever or whatever caused the patient to become angry.
   2. Guide the patient so that the anger will be expressed without harming self or others.
   3. Expressing anger is healthier than "bottled-up" or denied anger.

F. Avoid behaviors that make the patient more suspicious. Do not:
   1. Whisper with others in the presence of the patient.
   2. Smile and look at the patient.
   3. Touch the patient unnecessarily.
   4. Maintain long periods of eye contact with the patient.
   5. Make promises.

G. Ask for clarification if you do not understand the patient.

H. If the patient is verbalizing delusions:
   1. Accept his/her need for the belief.
   2. Communicate that you do not agree with this.
   3. Encourage the patient to talk more about his/her feelings in relation to the delusion.

I. If the patient is hallucinating:

   1. Find out what the voices are saying.

   2. Observe when the hallucinations occur most frequently.

   3. Attempt to distract the patient when hallucinating by engaging in some activity.

   4. Avoid trying to reason patient out of his/her delusional thinking or hallucinations.

J. Assist when necessary with activities of daily living.

K. Observe for safety hazards in the environment.

IV. Summary and Conclusion

   A. Key concepts related to the patient who copes by withdrawal

   B. Common signs and symptoms of the person who copes by withdrawing from reality

   C. Nursing interventions

   In this lesson, we have discussed key concepts, signs and symptoms, and nursing interventions for the patient who copes by withdrawing from reality.

LESSON PLAN: 19

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-9

INTERACTION ITEMS:

1. What does nursing focus on instead of the patient's diagnosis and why?

2. Why is it important not to label a patient?

3. What are some of the symptoms the patient who copes by withdrawing from reality exhibit?

4. What should you do if the patient keeps talking about his/her delusions?

5. What should you do if the patient is hallucinating?

6. Why is it important to establish a trusting relationship with this type of patient?

7. Why is it important to avoid behavior that may make a patient more suspicious?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

1. Have the students voluntarily present examples of situations they have had with patients who cope by withdrawing from reality that they thought were difficult for them to deal with. Explore with the group different ways of handling the situations. The instructor can use role play to demonstrate suggested interventions.

2. Have selected students present to the class a case study of a patient who copes by withdrawing from reality. Include the following information:

    a. Behavior on the unit
    b. Suggested nursing interventions from the plan of care
    c. Nursing interventions the student used
    d. Results of nursing interventions the student used
    e. Psychotropic medications the patient was taking

        1) Purpose of the drug
        2) Side effects that are possible
        3) Side effects actually observed

Handout #1

NURSING INTERVENTIONS

THE WITHDRAWN PATIENT

PATIENT'S BEHAVIOR	SUGGESTED NURSING CARE
1. Confusion, peculiar actions	1. Recognize confusion. Present plans in a simple, direct manner.
2. Thoughts subjective, not reality-oriented	2. Emphasize reality in every contact; protect patient from overwhelming situations.
3. Feelings of insecurity, isolation	3. Use a warm, friendly approach.
4. Not cooperative with ward activities	4. Give appropriate explanations, allow patient time to comply; be flexible about accepting modifications.
5. Neglect of grooming, hygiene, and/or elimination	5. Encourage and supervise, use praise to reinforce. Help establish regular elimination habits. Physical exercise also helpful.

THE SUSPICIOUS PATIENT

PATIENT'S BEHAVIOR	SUGGESTED NURSING CARE
1. Environment viewed as hostile and threatening	1. Be matter of fact, do not whisper or act secretive.
2. Thinking illogical and inappropriate to external situation	2. Give concise explanations of routines and prescribed procedures.
3. Attitudes of superiority, aloofness	3. Do not allow isolation from other patients and staff. Reinforce self-esteem to reduce feelings of inadequacy.
4. Symbolic speech and/or mannerisms in response to thought disorder	4. Analyze symbolism to determine underlying message.
5. Somatic complaints, frequently of chronic disabling disease	5. Direct attention toward other areas. Never ignore complaints but do not show great concern.

THE SUSPICIOUS PATIENT (cont.)

PATIENT'S BEHAVIOR	SUGGESTED NURSING CARE
6. Neglect of grooming and hygiene due to preoccupation	6. Give assistance when appropriate, allowing patient to progress in self-reliance.

LESSON PLAN: 20

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

SCOPE OF UNIT:

This unit is designed to provide the Psychiatric Aide II with current techniques and interventions in psychiatric nursing. It will include cultural aspects of behavior, the patient and his/her family, group therapy, current therapies, and specific patient behaviors that require interventions.

INFORMATION TOPIC: III-10 OR DEMONSTRATION: _______

THE PATIENT WHO COPES BY TURNING AGGRESSION INWARD
(Lesson Title)

LESSON OBJECTIVE - THE STUDENT SHOULD BE ABLE TO:

1. Identify five key concepts related to depression.
2. Identify five losses patients can experience when hospitalized that can lead to depression.
3. Recall ten common signs and symptoms of depression.
4. Recall ten nursing interventions for the patient who turns aggression inward.
5. Demonstrate in the clinical area how to give nursing care as outlined on the plan of care to an assigned patient who copes by turning aggression inward.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Handout #1: Depression Continuim
2. Handout #2: Nursing Interventions

INFORMATIONAL ASSIGNMENT: (Student)

Heimericks, Belinda. Psychiatric Aide I. Columbia, MO: Instructional Materials Laboratory, University of Missouri-Columbia, 1982, pp. 679-686b.

REFERENCES: (Instructor's Additional Information)

Davison, Gerald C. and Neale, John M. Abnormal Psychology. 3rd ed., New York: John Wiley and Sons, Inc., 1982, pp. 229-269.

Haber, Judith, et al. Comprehensive Psychiatric Nursing. St. Louis: McGraw-Hill Book Company, 1978, pp. 452-454.

Pasquali, Elaine A., et al. Mental Health Nursing: A Bio-Psycho-Cultural Approach. St. Louis: C.V. Mosby Company, 1981, pp. 379-430.

INTRODUCTION:

People who turn their aggression inward are commonly described as depressed. Depression is characterized by a feeling of sadness and other symptoms that last over a long period of time. It is a very painful mental illness that you will see frequently among the patients. It may be their primary problem or it may be secondary to another problem. In this lesson, we will discuss what you can do to aid the patient suffering from depression.

LESSON PLAN: 20

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III: MENTAL HEALTH NURSING

INFORMATION TOPIC: III-10

OUTLINE: (Key Points)

I. Key Concepts Related to Depression
  A. Experienced by everyone to some degree (See Handout #1.)
  B. Very common disorder
  C. Associated with grief such as the death of a loved one
    1. Denial
    2. Anger
    3. Bargaining
    4. Despair
    5. Acceptance
  D. Associated with loss
    1. Occurs as we progress through individual and/or family developmental stages
    2. Occurs when ill and hospitalized
    3. Events in day to day living
      a. Changing jobs
      b. Moving
  E. Sometimes no cause can be identified.

II. Losses Patients Can Experience When Hospitalized That Can Lead to Depression
  A. Independence
  B. Familiar surroundings
  C. Role in family

D. Role in society

E. Self-concept

III. Common Signs and Symptoms of Depression

A. Sadness

B. Poor appetite

C. Weight loss

D. Sleep problems

1. Difficulty falling asleep

2. Waking up early

3. Difficulty falling asleep after waking during the night

4. Drowsiness through the day

5. Excessive sleeping all through the day and night

E. Change in activity level

1. Lethargy

2. Agitation

F. Loss of interest in surroundings and activities

G. Lack of energy

H. Feelings of worthlessness

I. Poor self-concept

J. Inability to make decisions

K. Poor concentration

L. Thinks more about death and suicide

M. Feelings of helplessness

N. Feelings of guilt

O. Ambivalence or changing feelings

P. Feelings of powerlessness

IV. Nursing Interventions

- A. Discourage dependent behavior
  - 1. Allow time for patient to act for himself/herself.
  - 2. Encourage the patient to make decisions.
- B. Be empathetic and not overly cheerful.
- C. Be supportive of the patient.
- D. Let the patient know you are available.
  - 1. You must initiate the relationship.
  - 2. The depressed patient will not seek you out.
- E. Encourage the patient to talk about his/her feelings.
  - 1. Do no probe, but encourage by:
    - a. Using listening
    - b. Remaining empathetic
  - 2. Do not deny feelings such as guilt and worthlessness when the patient expresses them.
  - 3. Do not get into an argument or debate about what he/she is feeling or should feel.
- F. Be honest and direct when communicating.
- G. Recognize that the patient is a unique individual.
- H. The patient may need to be encouraged to join in activities.
  - 1. Mr. Jones, let's go to O.T. now.
  - 2. Miss Smith, let's go for a walk before lunch.
- I. Assist with hygiene needs when necessary.
- J. Observe to see that the patient is eating balanced meals.
- K. Be on the lookout for safety hazards such as improper lighting and objects that may cause falls.

V. Summary and Conclusion

- A. Key concepts related to depression

B. Losses patients can experience when hospitalized that may lead to depression

C. Common signs and symptoms of depression

D. Nursing interventions

In this lesson, we have talked about patients who cope by turning aggression inward, more commonly referred to as depression. The depressed person is usually quiet and can easily become labeled the "good" patient. As a Psychiatric Aide II, you should take an active approach in establishing a therapeutic relationship with this patient.

LESSON PLAN: 20

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-10

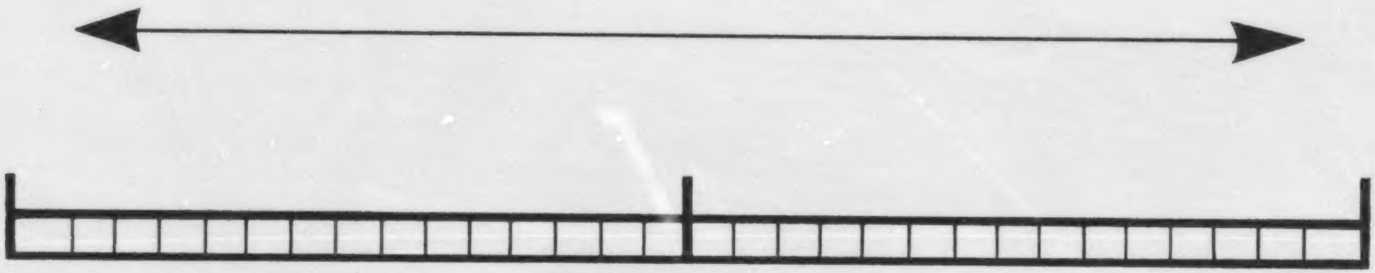
INTERACTION ITEMS:

1. Why should depression be thought of as being on a continuim?
2. Can depression occur as a result of hospitalization? If yes, why?
3. What are signs and symptoms of depression?
4. What is meant by dependent behavior?
5. Why should you discourage dependent behavior among depressed patients?
6. Why is it necessary for the aide to initiate the relationship?
7. Do patients who are depressed need assistance with hygiene?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

1. Have the students present examples of situations they have had with depressed patients that they thought were difficult. Explore with the group different ways of handling the situations. The instructor can use role play to demonstrate suggested techniques.
2. Have selected students present to the class a case study of a patient who copes by turning aggression inward. Include the following information:
    a. Behavior on the unit
    b. Suggested nursing interventions from the plan of care
    c. Nursing interventions the student used
    d. Results of nursing interventions the student used
    e. Psychotropic medications the patient is taking
        1) Purpose of the drug
        2) Side effects that are possible
        3) Side effects actually observed

Depression is a continuum.



Mild **Moderate** **Severe**

Depression is experienced by everyone in varying degrees.

Handout #1

Handout #2

NURSING INTERVENTIONS

The Depressed Patient

PATIENT'S BEHAVIOR	SUGGESTED NURSING CARE
1. Feelings of sadness, hopelessness	1. Show a sincere interest but avoid overcheerfulness.
2. Feelings of unworthiness	2. Encourage patient to contribute to ward, to work to "earn."
3. Thoughts slow, limited to few ideas	3. Allow patient time to understand and respond; keep conversation simple.
4. Frequently confused	4. Present plans for patient in a simple, direct manner.
5. Feelings of anxiety, apprehension	5. Keep choices and decision making to minimum, but allow patient to participate.
6. Attention span limited	6. Plan simple tasks of short duration.
7. Frequent complaints of imagined bodily ills and odors	7. Focus patient's attention elsewhere.
8. Neglect of grooming, hygiene, elimination	8. Give appropriate encouragement and support; monitor physical condition to prevent illness.

LESSON PLAN: 21

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

SCOPE OF UNIT:

This unit is designed to provide the Psychiatric Aide II with current techniques and interventions in psychiatric nursing. It will include cultural aspects of behavior, the patient and his/her family, group therapy, current therapies, and specific patient behaviors that require interventions.

INFORMATION TOPIC: III-11 OR DEMONSTRATION: ______

THE PATIENT WHO BECOMES ELATED
(Lesson Title)

LESSON OBJECTIVE - THE STUDENT SHOULD BE ABLE TO:

1. Identify six key concepts related to the patient who becomes elated.
2. Recall twelve common signs and symptoms of the patient who becomes elated.
3. Recall eight nursing interventions for the patient who becomes elated.
4. Demonstrate in the clinical area how to give nursing care from the plan of care to an assigned patient who becomes elated.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

INFORMATIONAL ASSIGNMENT: (Student)

Heimericks, Belinda. *Psychiatric Aide I*. Columbia, MO: Instructional Materials Laboratory, University of Missouri-Columbia, 1982, pp. 687-693a.

REFERENCES: (Instructor's Additional Information)

Davison, Gerald C. and Neale, John M. *Abnormal Psychology*. 3rd ed., New York: John Wiley and Sons, Inc., 1982. pp. 229-270.

Haber, Judith, et.al. *Comprehensive Psychiatric Nursing*. St. Louis: McGraw-Hill Book Co., 1979. pp. 325-339.

Pasquali, Elaine, et.al. *Mental Health Nursing; A Bio-Psycho-Cultural Approach*. St. Louis: C. V. Mosley Co., 1982. pp. 391-396.

INTRODUCTION:

In this lesson, we will discuss the patient who becomes elated. This patient's hyperactive behavior poses special problems for the nursing staff which you, as a PA II, will be expected to deal with. Patience, firmness, and consistency are a must when working with the hyperactive patient. Limit setting is also a must. We will discuss appropriate nursing interventions including tips on limit setting as well as characteristic signs and symptoms of the elated patient.

LESSON PLAN: 21

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-11

OUTLINE: (Key Points)

I. Key Concepts Related to the Patient Who Becomes Elated

  A. The elated patient exhibits hyperactive behavior.

    1. Associated with the manic phase of manic-depressive or bipolar disorder

    2. Is an excessive response to stimuli

    3. Mirror image of depression

  B. The elated patient does not recognize his/her problem.

    1. Exaggerated feeling of well-being - euphoria

    2. Difficult to get to come voluntarily for treatment

  C. May experience wide mood swings

    1. Changes can occur in a matter of hours

    2. Swings from euphoria to severe depression

  D. Reacts forcefully to

    1. People

    2. Places

    3. Things

  E. Lithium is the most effective treatment (Review information on Lithium, p. 174.)

  F. Strong indication that there is a genetic predisposition for the disorder

    1. Higher incidence among relatives

    2. Some sort of stress may trigger disorder

II. Common Signs and Symptoms

- A. Short attention span
- B. Irritable
- C. Poor concentration
- D. Impulsive
- E. Accelerated moter activity
- F. Speaks rapidly - may be difficult to follow the patient's train of thought
- G. Very outgoing
- H. Low self-esteem
- I. Grandiose ideas
- J. May spend large sums of money
- K. Inappropriate dress
  - 1. To season
  - 2. Bright colors
  - 3. Excessive jewelry
  - 4. Excessive make-up
- L. May horde items
- M. Neglects eating, sleeping, and personal hygiene

III. Nursing Interventions

- A. Decrease the stimuli in the environment
  - 1. Remove unnecessary furniture
  - 2. Take pictures off the wall
  - 3. Tone down bright harsh colors
  - 4. Eliminate excessive noise
  - 5. Assign patient to a private room
- B. Keep number of contacts with people to a minimum
  - 1. Assign the same person to care for the patient

    2. Discourage patients and personnel from visiting with him/her.
    3. Limit participation in groups.

C. Supervise personal hygiene.
    1. Gather toilet items.
    2. Regulate temperature of shower or bath.
    3. Assist in selecting appropriate clothing
    4. Assist and/or instruct as necessary

D. Provide regular, supervised activities.
    1. Noncompetitive
    2. Solitary or small groups
    3. Select activities that expend energy.
        a. Swimming
        b. Walking
        c. Running

E. Select projects that can be completed in a short time and expend energy.

F. Communicate therapeutically.
    1. Listen quietly and attentively.
    2. Try to steer back on track when the patient's train of thought wanders
    3. Interaction sessions should be short and frequent
    4. Give short, simple, and direct explanations.

G. Carry out limits set by the treatment team.
    1. Be firm and consistent.
    2. Help the patient understand the reason for the limit.
    3. Enforce consequence quickly if the patient goes beyond the limit.
    4. Assist the patient in identifying alternative behaviors.

H. Provide nutritious meals

   1. Provide with high calorie finger foods

   2. Arrange for six small meals versus three large ones.

   3. Encourage the patient to drink 8 glasses of water daily.

IV. Summary and Conclusion

   A. Key concepts related to the patient who becomes elated

   B. Common signs and symptoms

   C. Nursing interventions

In this lesson, we discussed the patient who becomes elated. Techniques for dealing with the patient were discussed along with signs and symptoms of the disorder. Remember: patience, consistency and firmness are the keys to a therapeutic relationship with this patient.

LESSON PLAN: 21

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-11

INTERACTION ITEMS: (Review Items)

1. Define euphoria.
2. What treatment is most effective in controlling hyperactive or elated behavior?
3. What are some of the characteristic symptoms of manic behavior?
4. Why is it necessary to set limits?
5. Why is it important to reduce stimuli to a minimum?
6. What kind of activities and projects are recommended for the elated patient?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

1. Have the students present examples of situations they have had with patients who were hyperactive that they thought were difficult. Explore with the group different ways of handling the situations. The instructor can use role play to demonstrate suggested techniques.
2. Have selected students present to the class a case study of a patient who copes by becoming elated. Include the following information:
    a. Behavior on the unit
    b. Suggested nursing interventions from the plan of care
    c. Nursing interventions the student actually used
    d. Results of nursing interventions the student actually used
    e. Psychotropic medications the patient is taking

LESSON PLAN: 22

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

SCOPE OF UNIT:

This unit is designed to provide the Psychiatric Aide II with current techniques and interventions in psychiatric nursing. It will include cultural aspects of behavior, the patient and his/her family, group therapy, current therapies, and specific patient behaviors that require interventions.

INFORMATION TOPIC: III-12 OR DEMONSTRATION: ______

THE PATIENT WHO MUST COPE WITH IMPAIRED BRAIN FUNCTION
(Lesson Title)

LESSON OBJECTIVE - THE STUDENT SHOULD BE ABLE TO:

1. Identify two key concepts related to the patient who must cope with impaired brain function.
2. Differentiate between the three types of impaired brain function frequently seen in a mental hospital.
3. Identify four group therapies used for treating the patient with impaired brain function.
4. Recall ten nursing interventions for patients with impaired brain function.
5. Demonstrate in the clinical area how to give nursing care from the plan of care to an assigned patient who suffers from impaired brain function.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

Handout #1: Geriatics - The Aging Patient

INFORMATIONAL ASSIGNMENT:

Heimericks, Belinda. Psychiatric Aide I. Columbia, MO: Instructional Materials Laboratory, University of Missouri-Columbia, 1982, pp. 701-707c.

REFERENCES: (Instructor's Additional Information)

Davison, Gerald C. and Neale, John M. Abnormal Psychology. 3rd ed., New York: John Wiley & Sons, Inc., 1982, pp. 484-553.

Pasquali, Elaine, et al. Mental Health Nursing: A Bio-Psycho-Cultural Approach. St. Louis: C.V. Mosby Company, 1981, pp. 565-603.

INTRODUCTION:

All of you will work with a patient with imparied brain function at some time in your career. In order to be therapeutic, you must have some understanding of your patient's condition. In this lesson, we will discuss what behaviors to expect from this type of patient as well as suggested nursing actions. We will also differentiate acute and chronic brain syndrome from mental retardation.

LESSON PLAN: 22

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-12

OUTLINE: (Key Points)

I. Key Concepts Related to the Patient Who Must Cope With Impaired Brain Function

A. Impaired brain function can result from a number of causes.

1. Traumatic injury from accidents
2. Poisonous gases, i.e., carbon monoxide
3. Cerebral vascular accident (stroke)
4. Arteriosclerosis (hardening of the arteries)
5. Drugs
6. Diseases in major body organs
    a. Liver
    b. Kidney
7. Diseases attacking the central nervous system
    a. Pick's Disease
    b. Alzheimer's Disease
    c. Huntington's Chorea
8. Serious infectious diseases
9. Chromsome abnormalities, i.e., Down's Syndrome
10. Metobolic disorders present at birth, i.e., PKU
11. Birth trauma

B. People with impaired brain function may develop mental illnesses the same as those without impaired brain function and may become:

1. depressed.

    2. psychotic.
    3. delusional.
    4. paranoid.
    5. elated.

II. Types of Impaired Brain Function Frequently Seen in a Mental Hospital

  A. Mental Retardation

    1. Definition: below average general intellectual functioning
    2. Usually recognized between the ages of 6 - 16 years
    3. Not treated in a hospital for the mentally ill unless there is a mental illness that warrants hospitalization
    4. Capabilities of the mentally retarded person affected by many factors:
      a. Enviromental stressors
      b. Visual/hearing impairments

  B. Acute Brain Syndrome

    1. Temporary condition resulting from a variety of causes
      a. Physical diseases
      b. Trauma
      c. Drug intoxacation
    2. Discuss at any age
    3. Is confused with organic brain syndrome in the elderly
    4. Characterized by:
      a. Sudden onset
      b. Difficulty focusing attention
      c. Poor concentration
      d. Disorientation

    - e. Swings in behavior and mood
    - f. Worse in the dark
  - 5. Usually lasts no longer than a week
  - 6. Differentiating factor from chronic brain syndrome is lucid periods usually in the early morning.
- C. Chronic or Organic Brain Syndrome
  - 1. Seen most frequently among the old and chronic alcoholics
  - 2. Difficulty in remembering most pronounced symptom
  - 3. Characterized by a gradual onset of symptoms
    - a. Memory is affected
    - b. Possibly disoriented
    - c. Poor judgement
    - d. Lose control of standards
    - e. Abstract thinking is poor
    - f. Easily excited and angered
    - g. Restless
  - 4. Develops characteristic speech patterns
    - a. Circumstantiality - include many irrelevant details when telling about something
    - b. Has difficulty remembering certain words and associating some words with others
    - c. Confabulation - fills in memory lapses with imaginary information
  - 5. Sleep patterns change - sleep less but need more time to rest in bed.

III. Group Therapies Used for Treating the Patient With Impaired Brain Function

- A. Reality orientation (Review Handout #1 on p. 205.)
  - 1. Members become more aware of their own identity.

2. Increases the interaction between the patients and nursing staff

3. Reorients to time, person, and place

4. Takes place 24 hours a day as well as in a group setting

B. Remotivation Group

1. Attempts to reinterest patients in the environment and other people

2. Discussions can be built around a variety of subjects.

a. Food

b. Current events

C. Reminiscence Group

1. Participants remember their past.

2. Life review is valuable for many reasons.

a. Increases the persons self-concept

b. Helps integrate self

c. Recall past coping methods that may help now.

d. Exercises memory

e. Recalls past successes

3. Progress in the group is measured by the members exhibiting:

a. More acceptance of change.

b. Greater attitudinal flexibility.

c. Hopefulness.

d. Personal integrity.

D. Socialization groups are effective for teaching the person various skills.

IV. Nursing Interventions For Patients With Impaired Brain Function

A. Remain calm and unhurried.

B. Be patient and supportive.

C. Be warm and accepting.

D. Use a kind tactful approach.

E. Encourage family members to visit.

  1. Can help stabilize the patient

  2. May help lessen the loneliness tha patient may experience

F. Re-orient to time, place, and person by:

  1. Calling the patient by name.

  2. Telling him/her your name.

  3. Reminding him/her of the place, date, and time.

  4. See that the patient has a small light on during the night because disorientation is greater after dark.

G. Establish a routine.

  1. Patients become more disoriented and confused if the routine is changed.

  2. Notify the patient of changes in advance.

H. Communication should be:

  1. Clear.

  2. Brief.

  3. Simple, step-by-step instructions.

  4. Correct the patient gently and consistently - do not agree with false statements.

  5. Look at the patient when conversing.

  6. Actively listen to the patient.

    a. Views about the present

    b. Reminiscence of the past

I. Limit the number of people caring for one patient.

J. Supervise the patient closely.

K. Be alert for safety hazards.

L. Assist with activities of daily living.

  a. Encourage the patient to do for himself/herself.

2. Observe that the patient eats well balanced meals.

3. Observe for bowel and bladder regularity.

K. Set Limits

Summary and Conclusion

A. Key concepts related to the patient who must cope with impaired brain function

B. Types of impaired brain function frequently seen in a mental hospital

C. Speech patterns characteristic among those suffering from impaired brain function

D. Common signs and symptoms exhibited by patients suffering from impaired brain function

E. Therapies used for treating the patient with impaired brain function

F. Nursing interventions for patients with impaired brain function

In this lesson, we have discussed causes of impaired brain function, characteristic speech patterns and common signs and symptoms of the patient with impaired brain funciton. This type of patient often needs to be gently reminded of time, place, and person. As a Psychiatric Aide II, you are with the patient more than any other team member, and, therefore, have the greatest opportunity for helping the patient remain reality oriented.

LESSON PLAN: 22

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-12

INTERACTION ITEMS:

1. What causes impaired brain function?
2. What are the three areas of behavior that change when the person has chronic brain syndrome?
3. Why is it necessary to differentiate chronic brain syndrome from mental retardation?
4. What is meant by circumstantiality?
5. What is meant by recall and association?
6. What is meant by confabulation?
7. What is a reminiscence group?
8. What are suggested nursing interventions for the patient with impaired brain function?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

1. Have the students voluntarily present examples of situations they have had with patients who must cope with impaired brain function that they thought were difficult to deal with. Explore with the group different ways of handling the situations. The instructor can use role play to demonstrate suggested interventions.
2. Have selected students present to the class a case study of a patient who must cope with impaired brain function. Include the following information:
    a. Behavior on the unit
    b. Suggested nursing interventions from the plan of care
    c. Nursing interventions the student used
    d. Results of nursing interventions the student used
    e. Psychotropic medications the patient was taking
        1) Purpose of the drug
        2) Side effects that are possible
        3) Side effects actually observed

Handout #1

Geriatrics - The Aging Person

General Principles

1. Aging begins at birth and proceeds at different rates in different individuals.
2. Aging proceeds at different rates in different systems in the same individual.
3. So many changes come with aging that these changes cannot be termed abnormalities.

I. Bodily changes that go with aging

- A. Nervous system
    1. Continous loss of brain cells
    2. Decrease in blood flow to the brain (blood carries oxygen to the cells)
    3. Increased reaction times and increased time in decision making - they appear slower
    4. Poor recent memory, but usually good memory of past events
    5. Personality changes
        - a. Loss of interest: failure to accept new ideas
        - b. Feelings of gloom and hopelessness
        - c. Abnormal possessiveness
        - d. Mental confusion - forgetfulness, somewhat scatterbrained
- B. Skin changes
    1. Skin becomes inelastic, wrinkled, and thinner, and veins are seen on the surface.
    2. Sweating decreases.
    3. Body unable to regulate temperature, feels cold even when weather is warm.
- C. Bone changes
    1. Loss of muscle power

2. Postural changes, joints stiffen

3. Increase in curvature of spine

D. Special senses changes

1. Vision - decrease in vision, a decrease in automatic adjustment to light, falling off of side vision

   a. Clinical problems include farsightedness, cataracts, and glaucoma.

2. Hearing - loss of hearing ability, inability to hear higher pitches, increased difficulty in hearing normal ranges of sound

3. Voice - lower tone, slowing of speech

4. Smell and taste - decrease in sense of smell and in number of taste buds

E. Heart changes

1. Heart

   a. Decrease in effective heart functions

   b. High blood pressure

F. Respiratory system changes

1. Less oxygen to the lungs

2. Decreased blood flow to lungs

3. Decline in total lung capacity

G. Gastrointestinal system changes

1. Decreased peristalsis - leads to chronic constipation

H. Urinary system changes

1. Decrease in kidney function

2. Reduction of blood flow to kidneys

I. Endocrine glands changes

1. Decrease in effectiveness of hormones

2. Decrease in glucose use - less energy

3. Decrease in adrenalin

4. Decreased basal metabolic rate
5. Decrease in body water (loss of actual weight)

J. Reproductive system changes

1. Menopause
2. Sexual activity sometimes impaired in men

K. Homeostasis (ability of body to restore balance)

1. Decrease in functioning of coordinating systems
2. Limited response to stress
3. Decreased functional reserve - more vulnerable to disease

II. Psychosocial influences of aging

A. Psychosocial aspects

1. Low self esteem from many losses
    a. Losses through death of spouse, children, friends
    b. Loss of social roles and resources, activities
    c. Socioeconomic losses - income
    d. Loss of work role - uselessness
2. Social isolation and loneliness
3. Lack of fight in daily difficulties
4. Decline in physical and mental capabilities
5. Sensory disabilities - makes individual suspicious and distrustful of others

B. Physical disabilities make it harder to adjust to a new environment.

C. Adaptive techniques used

1. Disengagement - mutual withdrawal between individual and society; can produce chronic depression
2. Activity - just to keep busy
3. Paranoid retreat
4. Integration - person accepts aging

III. Medical and nursing management

- A. Preventive care
  - 1. Encourage periodic health checkups.
  - 2. Prevent falls by observing environment.
  - 3. Avoid temperature extremes.
- B. Nutritional considerations
  - 1. Caloric intake should be reduced.
    - a. Metabolic rate and activity decrease
    - b. Calcium intake should be increased.
    - c. Adequate fruit and vegetable intake
  - 2. Factors affecting nutritional habits
    - a. Social factors (eating alone)
    - b. Poor dental health
    - c. Shopping problems
    - d. Decreased appetite
- C. Nursing approach to the confused elderly
  - 1. Changes in mental status may be first signs of physical illness
  - 2. A new environment may bring on senile behavior
    - a. Pay attention to what he is saying; often a person who is considered confused is only partly so, and much of what he says will make sense.
    - b. Try to touch patient to keep him in reality.
    - c. Call the person by name each time a contact is made.
    - d. Keep patient oriented by keeping a calendar and clock within his range of vision.
    - e. Put patient's activities on a routine schedule.
    - f. Encourage visitors anytime.
    - g. Keep a night light on during sleep.
    - h. Remove stressful stimuli

3. Plan of care

   a. Consult patient for his preferences.

   b. Ask patient's opinions.

   c. Encourage patient to make choices and decisions.

   d. Urge patient to remain active.

*The nursing approach must communicate to the patient that he has value as an individual and status in society.

Prepared by Western Missouri Mental Health Center

LESSON PLAN: 23

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III: MENTAL HEALTH NURSING

SCOPE OF UNIT:

This unit is designed to provide the Psychiatric Aide II with current techniques and interventions in psychiatric nursing. It will include cultural aspects of behavior, the patient and his/her family, group therapy, current therapies, and specific patient behaviors that require interventions.

INFORMATION TOPIC: III-13 OR DEMONSTRATION: ______

THE PATIENT WHO COPES BY BECOMING SOCIALLY DEVIANT
(Lesson Title)

LESSON OBJECTIVE - THE STUDENT SHOULD BE ABLE TO:

1. Identify six key concepts related to the patient who copes by becoming socially deviant.
2. Identify six characteristics of the patient who copes by becoming socially deviant.
3. Recall five nursing interventions for the patient who copes by becoming socially deviant.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

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INFORMATIONAL ASSIGNMENT: (Student)

Heimericks, Belinda. Psychiatric Aide I. Columbia, MO: Instructional Materials Laboratory, University of Missouri-Columbia, 1982, pp. 709-716a.

REFERENCES: (Instructor's Additional Information)

Davison, Gerald C. and Neale, John M. Abnormal Psychology. 3rd ed., New York: John Wiley & Sons, Inc., 1982. pp 272-294.

Haber, Judith, et.al. Comprehensive Psychiatric Nursing. St. Louis: McGraw-Hill Book Co., 1978. pp. 282-305.

Pasquali, Elaine, et.al. Mental Health Nursing; A Bio-Psycho-Cultural Approach. St. Louis: C.V. Mosby Co., 1981, pp. 432-501.

INTRODUCTION:

The patient who is socially deviant is one of the most difficult patients to treat for a variety of reasons. As a PA II, you must constantly be on guard for his/her attempts to get you to break the rules. This patient may appear to be a model patient when in actuality he/she is attempting to gain the staff's trust to gratify his/her own needs. Remember that this patient is very good at playing staff members against one another. In this lesson, we will discuss how you can guard against this patient's attempts at manipulation and be therapeutic.

LESSON PLAN: 23

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-13

OUTLINE: (Key Points)

I. Key Concepts Related to the Patient Who Copes By Becoming Socially Deviant

    A. Little understood personality disorder that is difficult to treat

        1. Does not respond to any medication

        2. Requires a very structured environment

    B. Cause of disorder unknown

        1. Theory that patient is underaroused and uses deviant behavior for stimulation

        2. Theory that parents, particularly father, model deviant behavior

    C. Many question where this patient should be treated

        1. Mental hospitals

        2. Prisons

    D. Habitually operate outside of the norms established by society

    E. Patient usually "burns out" around age 50

    F. Therapeutic community is most effective milieu

        1. Peers establish and enforce rules

        2. Peer pressure very effective

II. Characteristics of the patient who copes by becoming socially deviant

    A. Exercises poor judgment.

        1. Little if any insight

    2. Does not learn from past mistakes
    3. Is not concerned about consequences of his/her actions
    4. Believes he/she will never get caught

  B. Rationalizes
    1. Thinks up acceptable reasons for behavior
    2. Puts up a good front

  C. Places blame on others
    1. Does not accept responsibility for own actions
    2. Unconcerned about the dilemmas this causes others

  D. Hostile
    1. Towards everyone and everything
    2. May not be displayed openly
    3. Not in patient's conscious awareness

  E. Separates self from others
    1. Has no commitments to others
    2. Disregards obligations
    3. Develops shallow interpersonal relationships

  F. Manipulates and/or exploits others
    1. Uses family, friends, and/or strangers to get what he/she wants
    2. Can be cunning, likable, and charming or ruthless and domineering
    3. Experiences little or no guilt over actions
    4. Takes advantage of any trust or kindness shown
    5. Makes promises with no intention of keeping them

III. Nursing interventions

  A. Set limits
    1. Be consistent, firm, and kind
    2. Inform the patient of the rules and abide by them

3. Enforce consequences quickly if a rule is not followed.

4. Recognize the patient's attempts to use you.

5. Do not be "taken-in" by the patient.

6. Follow treatment program guidelines to the "letter" - the patient will use your infractions against you for his/her benefit.

B. Be alert for hostility

1. Point out to the patient your observations.

2. Encourage patient to explain hostile feelings.

3. Assist in identifying more appropriate ways of expressing hostility

D. Do not become defensive if your own values are questioned by the patient.

1. An attempt by the patient to undermine you

2. Be aware of your position.

D. Communicate acceptance of the patient. The behavior is unacceptable.

E. Keep the patient talking about self

1. Do not allow the patient to turn the conversation to you.

2. Do not talk much about yourself.

3. Remind the patient you are there to discuss his/her feelings.

IV. Summary and conclusion

A. Key concepts related to the patient who copes by becoming socially deviant

B. Characteristics of the patient who copes by becoming socially deviant

C. Nursing interventions for the patient who copes by becoming socially deviant

In this lesson, we have discussed key concepts and characteristics of the patient who is socially deviant. We stressed the importance of setting limits with this patient because a very structured environment is the most successful form of treatment.

LESSON PLAN: 23

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-13

INTERACTION ITEMS: (Review Items)

1. What are characteristics of the socially deviant patient?
2. Why are they so difficult to treat?
3. Why is a therapeutic community the most effective type of milieu?
4. What are the important points to remember about limit setting?
5. Why is it so important to set limits?
6. What are other effective nursing interventions with this patient?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

Use the role plays on p. 715 of the PA I Curriculum Guide.

Have the students present examples of situations they have had with patients who were socially deviant that they thought were difficult situations. Explore with the group different ways of handling these situations. The instructor can use role play to demonstrate suggested techniques.

LESSON PLAN: 24

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

SCOPE OF UNIT:

This unit is designed to provide the Psychiatric Aide II with current techniques and interventions in psychiatric nursing. It will include cultural aspects of behavior, the patient and his/her family, group therapy, current therapies, and specific patient behaviors that require interventions.

INFORMATION TOPIC: III-14 OR DEMONSTRATION: ______

THE PATIENT WHO COPES BY USING DRUGS AND ALCOHOL
(Lesson Title)

LESSON OBJECTIVES - THE STUDENT SHOULD BE ABLE TO:

1. Differentiate between substance abuse and substance dependence.
2. Identify eight characteristics of the substance abuser.
3. Identify four behavior problems common to the substance abuser.
4. Recall six types of substances commonly abused.
5. Recall the signs and symptoms of withdrawal from the five categories of substances commonly abused.
6. Recall in writing nursing interventions described for setting limits, role modeling, communicating, and maintaining a therapeutic environment.
7. List two therapies frequently used in treating substance abusers and their families.
8. Demonstrate how to give nursing care as outlined on the plan of care to an assigned patient in the clinical area.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Handout #1: The Alcohol Withdrawal Syndrome
2. Handout #2: Approaches to Use With the Person Dependent Upon Alcohol
3. Handout #3: Usual Reactions to Drugs
4. Film: "Chalk Talk" (Missouri Division of Health)

INFORMATIONAL ASSIGNMENT: (Student)

REFERENCES: (Instructor's Additional Information)

Davison, Gerald C. and Neale, John M. Abnormal Psychology. 3rd ed., New York: John Wiley and Sons, Inc., 1982, pp. 295-338.

Haber, Judith, et al. Comprehensive Psychiatric Nursing. St. Louis: McGraw-Hill Book Co., 1978. pp. 282-305.

Pasquali, Elaine A., et al. Mental Health Nursing: A Bio-Psycho-Cultural Approach. St. Louis: C.V. Mosby Company, 1981, pp. 431-500.

Schultz, Judith and Dark, Sheila L. Manual of Psychiatric Nursing Care Plans. Boston: Little, Brown and Company, 1982, pp.103-116.

INTRODUCTION:

In the hospital we are frequently in contact with patients who are experiencing difficulty with alcohol and/or other drugs. These people can be very difficult to work with because of their desire for the addictive substance, their manipulative behavior, and denial and/or rationalization of the problem. However, we must remember that substance abuse is an illness that requires treatment rather than punishment and ridicule.

LESSON PLAN: 24

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-14

OUTLINE: (Key Points)

I. Differentiation Between Substance Abuse and Substance Dependence
  A. Substance abuse
    1. Over-use of a substance
    2. Unable to decrease quantity used
    3. No physiological dependence
    4. Psychological dependence
  B. Substance dependence or addiction
    1. Physiological dependence
    2. Tolerance for the substance occurs which results in the person taking increased amounts of the substance in order to experience the desired effects
    3. Withdrawal symptoms occur when the substance is not taken.

II. Characteristics of the Substance Abuser
  A. Guilt
  B. Low self-esteem
  C. Dependence
  D. Self-destructiveness
  E. Anxiety
  F. Confusion and self-doubt
  G. Passive
  H. Compulsive
  I. Difficulty tolerating frustrations and anxiety
  J. Difficulty with interpersonal relationships

- K. Anger
- L. Idealistic and given to wishful thinking
- M. Overly sensitive

III. Common Behavior Problems

- A. Manipulation
- B. Impulsive behavior
- C. Withdrawal
- D. Exaggerated feelings of importance and power
- E. Denial
- F. Rationalization of behavior
- G. Blaming

IV. Types of Substances Commonly Abused

- A. Stimulants
  - 1. Cocaine
    - a. Speed
    - b. Coke
  - 2. Amphetamines
    - a. Pep pills
    - b. Bennies
    - c. Cart wheels
- B. Hallucinogens or psychedelics
  - 1. LSD
    - a. Acid
    - b. Cubes
    - c. Royal blue
  - 2. Mescaline - mesc
  - 3. Psilocybin
    - a. God's flesh
    - b. Mushroom

        4. Marijuana
            a. Mary Jane
            b. Tea
            c. Grass
    C. Sedatives, depressants
        1. Barbiturates
            a. Goofballs
            b. Barbs
            c. Birds
    D. Tranquilizers
        1. Librium
        2. Valium
    E. Solvents
        1. Glue
        2. Gasoline
        3. Paint thinner
        4. Lighter fluid
    F. Alcohol

V. Signs and Symptoms of Substance Withdrawal
    A. Alcohol
        1. Flushed face, bloodshot eyes
        2. Mild tremors
        3. Nausea/Vomiting
        4. Marked increase in activity
        5. Anorexia
        6. Acute anxiety
        7. Nightmares
        8. Illusions

9. Hallucinations
    a. Auditory
    b. Visual
    c. Olfactory and tactile, occasionally
10. Grand mal seizures
11. Profound confusion (See Handout #1)

B. Stimulants
1. Aggression
2. Hyperactivity
3. Irritability
4. Insomnia
5. Dilated pupils
6. Hypertension
7. Tachycardia
8. Paranoia
9. Elevated temperature
10. Convulsions
11. Coma
12. Death

C. Hallucinogens or psychedelics
1. Extreme anxiety, possibly panic
2. Confusion
3. Incoherence
4. Hallucination, usually visual
5. Implusive, sometimes life-threatening and aggressive behavior

D. Sedatives
1. Flushed face
2. Bradycardia

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3. Decreased respirations to possible apnea
4. Disorientation
5. Drowsiness
6. Speaking difficulty
7. Hallucinations
8. Suspicion
9. Restlessness
10. Hypotension
11. Coma, possible death

E. Narcotics

1. Dilated pupils
2. Hypotension
3. Tachycardia
4. Lethargy
5. Yawning
6. Watery eyes or tearing of eyes
8. Muscular aches, twitching
9. Anorexia
10. Nausea
11. Vomiting
12. Chills
13. Fever
14. Gooseflesh
15. Restlessness

VI. Nursing Interventions

A. Setting limits

1. Clearly define the expected behavior and communicate this to the patient, staff, and family.
2. Be firm and consistent

3. Help the patient understand the reason for the limit.

4. Clearly define consequences for going beyond the limits and communicate these to the patient, staff, and family.

5. Enforce consequences quickly if patient goes beyond the limit.

6. Assist the patient in finding alternative behaviors.

7. Avoid power struggles with the patient.

8. Communicate frequently with other staff members to prevent the patient from playing one staff person against another.

B. Role modeling

1. Set standards for behavior and act in accordance with these standards.

2. Demonstrate through own behavior how to cope with:

    a. Making mistakes

    b. Handling anger

    c. Consequences of behavior

    d. Accepting responsibility for behavior

    e. Alternative behavior

C. Communicating

1. Patient behavior

    a. Remains superficial and noncommital in discussions

    b. Attempts to shift topic by asking personal questions of staff member

2. Staff response

    a. Point out that discussion is about the patient and return to original topic. (Don't fall into the trap of being led off the subject by the patient getting you to talk about yourself.)

    b. Avoid arguing, making demands for reasons why, or making accusations.

    c. Be kind, firm, and objective.

D. Maintaining a therapeutic environment

1. Know where patient is and what patient is doing.

2. Supervise in group activities.

3. Keep busy with a variety of activities.

4. Be alert for rising tensions between patient and others.

5. Be alert for contraband.

VII. Therapies Frequently Used in Treating Substance Abusers and Their Families

A. AA (Alcoholics Anonymous)

B. Alanon

C. Alateen

D. Individual Therapy

E. Group Therapy

VIII. Summary, Conclusion, and Assignment

A. Differentiates between substance abuse and substance dependence.

B. Characteristics of the substance abuser

C. Common behavior problems

D. Types of substances commonly abused

E. Signs and symptoms of substance withdrawal

F. Nursing interventions

G. Therapies frequently used in treating substance abusers and their families

In this lesson, we have defined substance abuse and substance dependence, and identified substances commonly abused. We have studied characteristics and behavior problems common to substance abusers, and nursing interventions for manipulative and impulsive behavior as well as for role modeling, communication, and maintaining a therapeutic environment.

LESSON PLAN: 24

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-14

INTERACTION ITEMS: (Review Items)

1. What is meant by substance abuse? dependence?
2. What are the characteristics of the substance abuser?
3. What substances are commonly abused?
4. What are the nursing interventions suggested for the substance abuser?
5. What are the signs and symptoms of alcohol withdrawal?
6. What are the signs and symptoms of stimulant withdrawal?
7. What are the signs and symptoms of sedative or depressant withdrawal?
8. What are the signs and symptoms of narcotic withdrawal?
9. What are the signs and symptoms of hallucinogen withdrawal?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

1. Have a guest speaker on alcoholism and drug abuse.
2. Role play situations in which the patient is trying to be very manipulative.
3. At the beginning of class, discuss your feelings toward substance abusers.
4. Your patient comes to you and tells you that the reason he began drinking was his wife's constant complaining about everything. He goes out of his way to please her, but he just can't do anything right. How would you respond?
5. Mr. J. has been on the ward about 3 or 4 days. This morning you find him in his room apparently carrying on a conversation, but no one else is in the room. It was reported at shift change that during the night, Mr. J. told the staff to be careful because of the ice and snow. (The month was August.) What do these symptoms suggest?

6. Have selected students present to the class a case study of a substance abuser. Include the following:

   a. Behavior on the unit

   b. Suggested nursing interventions from the plan of care

   c. Nursing interventions the student actually used

   d. Results of nursing interventions the student actually used

   e. Psychotropic medications the patient is taking

THE ALCOHOL WITHDRAWAL SYNDROME

Stage	Onset	Signs and Symptoms	Duration
I Tremulousness	Approximately 8 hours after cessation or reduction of heavy drinking.	Flushed face, bloodshot eyes, mild tremors, nausea and vomiting may be present.	Few days
	Maximum intensity reached in about 24 hours.	Marked increase in psychomotor activity, anorexia insomnia, tachycardia, agitation, hypertension, and acute anxiety	May take 10-14 days.
II Hallucinosis	Approximately 24 hours.	Nightmares or "bad dreams", illusions, visual, auditory, occasional olfactory or tactile hallucinations. Visual hallucinations are not perceived as threatening, however, auditory hallucinations are almost always maligning or threatening in nature, and the patient's behavior is appropriate to the hallucinatory content which may be evident in suicidal or homicidal tendencies.	1-6 days
III Convulsions	From 12-48 hours.	Grand-mal seizure. May be only one, but in the majority of cases occur in two to six or more.	
IV Delirium Tremens	Generally 3-5 days, sometimes up to 12.	Profound confusion, hallucinations, delusions, agitation, sleeplessness, as well as increased autonomic activity, i.e., fever, tachycardia, hypertension, profuse perspiration, and tachypnea.	1-3 days.

Prepared by: Mid-Missouri Mental Health Center
Nursing Education Department

Handout #1

Handout #2

Approaches To Use With The Person Dependent Upon Alcohol

Attitude or Approach	Concept or Principles
Acute Withdrawal	**Impending Delirium Tremers**
1. Provide protective supervision to prevent injury	1. Person may be confused and disoriented
2. Provide a quiet atmosphere that is well lighted and avoid sudden abrupt approach	2. May be easily excited
3. Encourage fluid intake and high protein diet	3. May be dehydrated and undernourished. Alcoholism ruins a person physically
4. Drugs are given to keep patient well sedated during withdrawal. Do not permit out of bed alone during widthdrawal and sedated periods	
5. Observe for maintenance of vital signs and convulsions	
6. Draw out his feelings of resentment, hopelessness, guilt and remorse	6. Treatment and nursing care of the alcoholic patient begins with understanding his personality and the problems from which he has a need to escape
Continuing Treatment	
7. Accept alcoholism as a disease that can be permanently arrested	7. The alcoholic must never be considered cured
8. Plan regular routines that provide an adequate amount of rest, work, socialization, and interaction with others	
9. Observe for symptoms of depression	9. May alcoholics have self-destructive tendencies
10. Accept the person without reservation	10. The treatment of the alcoholic cannot be accomplished by rejection from personnel
11. Give emotional support through sincere interest and attention without becoming overly sympathetic	11. The permanent rehabilitation of the alcoholic is largely influenced by his personal motivation to give up his emotional crutch

Handout #3

Usual Reaction to Drugs

Signs and symptoms	Sedatives and depressants	Stimulants	Narcotics	Hallucinogens	Tranquilizers	Solvents
Behavioral						
Aggression	A*	A		A		
Depression	A	W				
Disorientation	A, W	A		A		
Euphoria		A	A	A		A
Drowsiness	A		A	A[1]	A	W
Hallucinations	A, W	A		A		
Inattentiveness	A		A			
Irritability	A	A				
Suspicion	W	A		A		
Restlessness	W	A	W	A		
Physical						
Slurred speech	A		A			
Gastrointestinal			A		A	
Respiratory	A	A	A			
Nasal			W[2]		A[3]	A
Lacrimation			W	A		A
Pinpoint pupils			A			
Dilated pupils	A	A	W	A		
Tachycardia		A	W	A	A	
Hypotension	A, W		A		A	
Skin rash	A	A			A	

*A, Acute phase; W, Withdrawal phase.

[1] Occasional

[2] Runny nose

[3] Nasal stuffiness

Reproduced with permission from Pasquali, Elaine Anne, Alesi, Eleanore Gorthey, Arnold, Helen Margaret, and DeBasio, Nancy: Mental health nursing, St. Louis, 1981, The C. V. Mosby Co.

LESSON PLAN: 25

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

SCOPE OF UNIT:

This unit is designed to provide the Psychiatric Aide II with current techniques and interventions in psychiatric nursing. It will include cultural aspects of behavior, the patient and his/her family, group therapy, current therapies, and specific patient behaviors that require interventions.

INFORMATION TOPIC: III-15 OR DEMONSTRATION: ______

PREVENTION OF ASSAULTIVE BEHAVIOR
(Lesson Title)

LESSON OBJECTIVE - THE STUDENT SHOULD BE ABLE TO:

1. Identify four key concepts related to the prevention of assaultive behavior.
2. Identify seven signs and symptoms of assaultive behavior.
3. Recall nine nursing interventions for preventing assaultive behavior.
4. Recall eight nursing interventions for managing assaultive behavior.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Handout #1: Types of Assaultive Behavior and Interventions for Each
2. Handout #2: Physical Restraint Techniques
3. Department of Mental Health Operating Regulations regarding seclusion and restraints
4. Facility Guidelines regarding seclusion and restraints

INFORMATIONAL ASSIGNMENT: (Student)

Heimericks, Belinda. Psychiatric Aide I. Columbia, MO: Instructional Materials Laboratory, University of Missouri-Columbia, 1982, pp. 655-666b.

REFERENCES: (Instructor's Additional Information)

Haber, Judith, et al. Comprehensive Psychiatric Nursing. St. Louis: McGraw-Hill Book Co., 1978, pp. 247-261.

Pribula, Sister Irene P., SSpS. "Disarming the Agitated, Combative or Destructive Patient," Free Association. Vol. 4, No. 1, Jan. - Feb., 1977.

INTRODUCTION:

The patient who is losing control can create a potentially dangerous situation that is frightening to the patient as well as patients and staff in the situation. Because you are with the patient more than other staff, you will probably become aware of his/her rising tension and anxiety before others. It is at this time that staff should intervene so as to prevent a major problem later on. The patients tend to calm down more quickly and are more secure when the staff person appears in control of the situation. In this lesson we will discuss methods for working with the patient in order to prevent a loss of control and assaultive behavior.

LESSON PLAN: 25
COURSE TITLE: PSYCHIATRIC AIDE II
UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-15

OUTLINE: (Key Points)

I. Key Concepts Related to the Prevention of Assaultive Behavior

- A. Two basic drives common to everyone
  - 1. Self Preservation
  - 2. Aggression
    - a. Necessary for self preservation
    - b. Channeled or sublimated
    - c. Healthy channeling of aggression
      - 1) Gratification of needs can be postponed
      - 2) Able to cope with frustrations
      - 3) Develops concern for the needs of others
      - 4) Learn to control and direct aggression into appropriate activities
    - d. Unhealthy expression of aggression
      - 1) Disregard for the needs of others
      - 2) Learned from modeling and lack of guidance from parents
- B. Conditions lending to assaultive behavior
  - 1. Functional or organic state
    - a. Psychotic states
    - b. Organic disorders
    - c. Depressed states
    - d. Impulsivity

    2. Feelings of powerlessness and loss of independence
    3. Objecting to treatment and/or hospital routine

  C. Goals of staff members
    1. Set limits.
    2. Maintain safety and security for everyone involved.

  D. Assaultive behavior situations cause some staff members to experience fear.
    1. Fear can be beneficial
      a. Increases alertness
      b. Increases flow of adrenalin
      c. Sharpens our senses
    2. Results when we lack knowledge
      a. Do not know the patient's response
      b. Do not know how we will respond
    3. Recognize when you are afraid
      a. Cannot be eliminated
      b. It can be controlled
      c. Controlling fear gives a greater feeling of self-confidence

II. Signs and Symptoms of Assaultive Behavior

  A. Verbal attacks toward others

  B. Increased activity

  C. Need for more space

  D. Stronger emotions

  E. Talks more about delusions, especially if threatening

  F. Hallucinations become:
    1. Commanding
    2. Threatening
    3. Upsetting in any way

G. Prior history of violence

H. Signs and sumptoms of four types of assaultive behavior (Review Handout #1)

   1. Fear

   2. Frenzy

   3. Temper tantrum

   4. Criminal assault

III. Nursing Interventions for Preventing Assaultive Behavior

A. Attempt to understand the patient's perceptions

   1. Of self

   2. Of situations

   3. How the two relate

B. Establish a rapport with the patient

   1. Know the patient and how he/she usually reacts.

   2. Know and be alert for the patient's early signs of tensions.

   3. Encourage the patient to ventilate and resolve feelings at this stage.

C. Use a supportive approach if anxiety is rising.

   1. Communicate that you want to help.

   2. Communicate that you understand.

D. Create a sense of safety and security.

E. Remain compassionate.

F. Communication should be brief and simple.

G. Consider a PRN medication - medication is better than forcefully restraining the patient.

H. Remain objective.

   1. Do not become defensive to verbal attacks.

   2. Be aware of your position.

3. Remain in control.

4. The patient will feel more secure when he/she senses your feeling of control.

I. Encourage the patient to identify what he/she is angry about.

IV. Nursing Interventions for Managing Assaultive Behavior

A. Remain in control.

1. Communicate a feeling of control.

2. Create a feeling of safety and security.

3. Do not get into a position in which you must defend yourself.

B. Be aware that talking to a patient may heighten feelings of anxiety and tension.

1. Does not mean poor communication skills

2. Talking is not effective at this time.

C. Be prepared to act quickly once decision has been made to set limits.

1. Do not change your mind or the patient will change it for you.

2. Remind the patient that no one will be harmed.

3. Do not approach the patient alone unless absolutely necessary.

4. Use a direct approach with verbal limits, such as:

a. "Don't hit me."

b. "Don't hurt yourself"

c. "Don't tear up the furniture."

d. "Don't hurt that person."

5. Do not challenge the patient.

D. Remain a distance (at least equal to the length of the patient's legs) away from the patient.

1. Keeps you outside his/her personal body space area

2. Tension and a need to defend one's territory rise when another invades the patient's personal space.

E. Work as a team and plan your approach if the patient must be physically restrained.

   1. Identify a person in charge.
   2. Discuss in advance what will be done, if possible.
   3. Clearly identify what shall be done and who is to do it.
   4. Remove articles that could cause bodily harm.
      a. Glasses
      b. Watches
      c. Pens and pencils
   5. Approach slightly to the side of the patient - less threatening.
   6. Hold joints firmly.
   7. Block swings.
   8. Walk to seclusion room without stopping.
   9. Walk patient backwards if struggling so as to keep off balance.
   10. Once in seclusion, remove personal articles from the patient that may cause bodily harm.
       a. Glasses
       b. Belts
       c. Matches
       d. Glass items
   11. Apply restraints as a last resort.
   12. Instruct patient to lie on floor or stay against wall until you have left room.
       a. Do not leave anyone alone in the room with the patient.
       b. Do not allow the patient to get between you and the door.

F. Monitor the patient frequently while he/she is in seclusion and/or restraints. (Review facility and departmental policies on seclusion and restraints.)

    1. Talk with the patient.
    2. Remain compassionate.
    3. Never ignore the patient.
    4. Serve meals with plastic utensils.
    5. If the patient does not eat, offer a sandwich later.
    6. Attend to elimination needs as necessary.
    7. Remove from seclusion and/or restraints as soon as possible.

G. One person should remain with the rest of the patients.

    1. Offer reassurance.
    2. Answer questions about what has happened.

H. Afterwards, evaluate the situation and how it might have been handled better.

V. Summary and Conclusion

A. Key concepts related to the prevention of assaultive behavior

B. Signs and symptoms of assaultive behavior

C. Nursing interventions for preventing assaultive behavior

D. Nursing interventions for managing assaultive behavior

In this lesson, we have discussed key concepts related to assaultive behavior. As previously stated, people have drives of aggression and self-preservation and will sometimes express these needs in an aggressive manner. When this happens, you will be expected to maintain the safety of the assaultive patient, yourself, and the remainder of the staff as well as the remainder of the patients on the unit.

LESSON PLAN: 25

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-15

INTERACTION ITEMS: (Review Items)

1. Why is it important to understand that aggression is a drive that everyone has?
2. What are indications that aggression has been channeled in healthy ways? Unhealthy ways?
3. What conditions lend themselves to assaultive behavior?
4. Why is it important to know if the patient has a history of violence?
5. What are some nursing interventions for preventing assaultive behavior?
6. What are some nursing interventions for managing assaultive behavior?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

1. Practice correctly applying restraints to one another in the classroom under the supervision of the instructor.
2. Present a hypothetical situation in which a patient has been placed in restraints and seclusion.
   Have the students:
    a. Discuss the care to be given the patient.
    b. Complete the necessary documentation on the appropriate nursing service forms.
3. Role play and discuss situations in which a patient is becoming tense and anxious and in which the patient becomes assaultive.
   Discuss:
    a. Statements used that were supportive and when they were used.

b. Statements used that were verbal limits or directive, and when they were used.

c. When talking did not work and physical restraints were necessary.

d. Your concerns during the situation.

e. Feelings of fear and how they were controlled.

Handout #1

Types of Assaultive Behavior and Interventions for Each

Symptom	Fear	Frenzy	Temper Tantrum	Criminal Assault
Posture	Defensive	Attacking		
Skin	Pale	Flushed		
Breathing	Rapid, Shallow & Irregular	Deep, Fast Like Hyperventilation		
Facies	Wide-Eyed Fright	Grotesque Grimace		
Action	Defense	Destruction		
Criteria			Confusion	Fear
Staff Affect			1) "Gimme"	1) Clear Request
Event Progression			2) Object Oriented Violence	2) Fear Inducing Contact
			3) Assault	3) Assault
History			Previous Similar Disruption at Work, in School or with Family	Previous Similar Episodes in Criminal Justice System

Main Task	Reduce Threat	Control	Avoid Playing	Protect Self

Staff Response	Fear	Frenzy	Temper Tantrum	Criminal Assault
Distance	10 - 12'	Just out of Reach	Out of Danger	Out of Danger
Position	Oblique Approach	Frontal Approach	Frontal	Oblique
Eye Contact	Infrequent - Looking Up	Direct, Constant	Absent	Direct
Posture	Open	Commanding	Ostracizing	Defensive
Gestures	Palm Up	Palm Down or Pointing	Absent	Self-Protective
Voice	Quiet, Reassuring	Barely Audible, Commanding	Quiet, Distant	Quiet, Confident
Words	Reassuring	Commanding	Commanding, Directed to Physical State	Self-Protective Threatening Only What Can Be Done

Prepared by Mid-Missouri Mental Health Center

PHYSICAL RESTRAINT TECHNIQUES

- * PATIENT SAFETY IS A PRIME RESPONSIBILITY OF ALL PERSONNEL WORKING IN THE FACILITY.
- * NEVER STRIKE A PATIENT.
- * NEVER USE MORE RESTRAINT THAN IS NECESSARY IN THE SITUATION.
- * NEVER RESTRAIN OUT OF ANGER OR DESIRE TO PUNISH.

1. Do not attempt to restrain a patient during an explosive outburst which does not immediately threaten the personal safety of staff or patients unless you are certain you will gain control.
2. Remove your jewelry and other potentially harmful apparel like watches or large, sharp, belt buckles.
3. Three to five is the ideal number of staff to be used in the physical restraint of a normal adult-sized person.
4. Ask one person to be responsible for making decisions. When decisions are made, carry them out with a minimum of delay.
5. Know what you are about to do, talk to other staff to minimize confusion.
6. Don't argue or discuss differences of opinion during the restraining process - settle differences of opinion at other times.
7. Talk to patient and call by name. Tell him/her you are providing control until he/she can control self.
8. Be firm with patient but not evasive.
9. Isolate patient if possible.
10. Always approach patient from side or behind if possible. Two to five persons, approaching from different directions, are best. This keeps patient's attention divided.
11. Put patient face down on floor - it is very difficult for patient to hurt him/her self or others in this position.
12. Don't grab patient by neck or throat - cutting off breath will increase struggle and may injure him/her.
13. Watch for bites, kicks, pinches - Don't put yourself in position to get injured.

14. If patient has a weapon of any sort (knife, ashtray, etc.) use a pillow or blanket to protect self. Always keep an object (chair, table) between you and weapon.

15. Divert attention of patient armed with weapon - throw a pillowcase, towel or other soft, floppy object at face.

16. If you are alone and must act, move in as close as possible to patient and hug tightly. This maneuver will minimize the chance of injury and may also give the patient a feeling of security.

17. Use assisting measures to protect other patients and staff.

* REMAIN AWARE THAT RESTRAINT CAN BE A HUMILIATING EXPERIENCE.

Restraining a patient is an often unpleasant but important task. Remain aware of the patient's feelings and your own feelings. If you are unduly frightened or uncomfortable in the situation, you should have someone else step in, if possible. Unless absolutely necessary, do not attempt to restrain a patient alone - always call for help. Do not restrain a patient unless it is necessary and therapeutic.

Taken from Mid-Missouri Mental Health Center, Psychiatric Aide I Course.

LESSON PLAN: 26

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

SCOPE OF UNIT:

This unit is designed to provide the Psychiatric Aide II with current techniques and interventions in psychiatric nursing. It will include cultural aspects of behavior, the patient and his/her family, group therapy, current therapies, and specific patient behaviors that require interventions.

INFORMATION TOPIC: III-16 OR DEMONSTRATION: ______

THE PATIENT WHO IS SUICIDAL

(Lesson Title)

LESSON OBJECTIVE - THE STUDENT SHOULD BE ABLE TO:

1. Identify six key concepts related to suicide.
2. Recall four criteria to measure the seriousness of the suicidal plan.
3. Recall ten high risk indicators for suicide.
4. Identify six nursing interventions for the suicidal patient.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

Facility guidelines regarding the suicidal patient

INFORMATIONAL ASSIGNMENT: (Student)

Heimericks, Belinda. Psychiatric Aide I. Columbia, MO: Instructional Materials Laboratory, University of Missouri, 1982, pp. 695-700a

REFERENCES: (Instructor's Additional Information)

Davison, Gerald C. and Neale, John M. Abnormal Psychology. 3rd ed., New York: John Wiley & Sons, Inc., 1982, pp. 261-268.

Hatton, Corrine L., et al. Suicide: Assessment and Intervention. New York: Appleton - Century - Crofts, 1977, pp. 39-61.

Pasquali, Elaine, et al. Mental Health Nursing: A Bio-Psycho-Cultural Approach. St. Louis: C.V. Mosby Company, 1981, pp. 396-400.

INTRODUCTION:

Suicide is of great concern. In the United States alone, someone takes their own life every thirty minutes. Suicide is found among all socioeconomic classes and professions and it is particularly high among the very old and very young. As a PA II, you will be very active in providing nursing care for the suicidal patient. The goal is to keep the patient safe and assist him/her in resolving the crisis.

LESSON PLAN: 26

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-26

OUTLINE: (Key Points)

I. Key concepts related to suicide

   A. High risk groups

      1. Men over age 35

      2. Rate Increases appreciably for men over age 65

   B. Men have a higher success rate

      1. Choose more lethal methods

      2. More attempts are made by women.

   C. Suicide occurs in all races and socioeconomic groups.

   D. Certain events sometimes precipitate suicidal attempts.

      1. Loss

         a. Significant person

         b. Status

         c. Job

         d. Home

      2. Threat - actual or perceived

      3. Anniversary dates

      4. Arrest

      5. Prosecution

   E. Suicide is considered a cry for help

      1. Subtle warnings precede attempts

      2. Suicidal people are ambivalent about taking their own lives.

    F. Suicide among children and adolescents is rising.

II. Four criteria to measure the seriousness of the suicidal plan

    A. Method

    B. Lethality of method

    C. Availability of method

    D. Detail of the plan

II. High risk indicators for suicide

    A. Detailed plan with available, lethal method

    B. Marked hostility

    C. Impulsive with poor judgement

    D. Past history of coping in destructive ways

    E. Few or no resources, i.e., money, job, home

    F. Severe anxiety

    G. Severe depression

    H. Feels hopeless and helpless

    I. No significant person

        1. Relative

        2. Neighbor

        3. Friend

    J. Unstable life style

    K. Continual use of drugs and/or alcohol

    L. Has been unable to perform activities of daily living

IV. Nursing interventions for the suidical patient

    A. Observe for any changes in the following

        1. Behavior

        2. Mood

        3. Eating patterns

    4. Sleeping patterns
    5. Weight gain or loss
  B. Know the whereabouts and activities of the suicidal patient 24 hours a day.
    1. 1:1 basis
    2. Watchfulness is the key to prevention.
  C. Find out if the patient is thinking about suicide.
    1. Patients generally answer honestly.
    2. Asking about suicide will not "put ideas into their heads."
    3. Maintain an empathetic and matter-of-fact attitude.
  D. Be alert for items in the environment that could be used by the patient to attempt suicide.
  E. Document observations about the patient.
  F. Do not take personally hostility expressed towards you by the patient.

V. Summary and Conclusion
  A. Key concepts related to suicide
  B. Four criteria to measure the seriousness of the suicidal plan
  C. High risk indicators for suicide
  D. Nursing interventions for the suicidal patient

In this lesson, we have discussed key concepts regarding suicide and criteria that will aid you in determining the seriousness of the plan. We have also identified high risk factors as well as nursing interventions for the suicidal patient.

LESSON PLAN: 26

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-16

INTERACTION ITEMS: (Review Items)

1. Why are more men successful with suicide than women?
2. Who are the high risk groups for suicide?
3. What events may precipitate suicide?
4. What are the criteria for assessing the seriousness of the plan?
5. What factors indicate a high risk for suicide?
6. What are the nursing interventions for the suicidal patient?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

1. Have the students voluntarily present examples of situations they have had with patients who were suicidal. Have the students discuss nursing interventions used and suggest other possible interventions. The instructor can use role play to demonstrate suggested interventions.

LESSON PLAN: 27

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

SCOPE OF UNIT:

This unit is designed to provide the Psychiatric Aide II with current techniques and interventions in psychiatric nursing. It will include cultural aspects of behavior, the patient and his/her family, group therapy, current therapies, and specific patient behaviors that require interventions.

INFORMATION TOPIC: III-17 OR DEMONSTRATION: ______

THE MENTALLY ILL PATIENT WHO HAS SEIZURES
(Lesson Title)

LESSON OBJECTIVE - THE STUDENT SHOULD BE ABLE TO:

1. Differentiate between the two major types of seizures
2. Identify two epileptic states.
3. Recall four symptoms of deterioration resulting from seizures.
4. Recall five nursing interventions for the patient having a seizure.
5. Recall three nursing interventions following the seizure.
6. Recall four observations to report and record.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

INFORMATIONAL ASSIGNMENT: (Student)

REFERENCES: (Instructor's Additional Information)

INTRODUCTION:

Many of the patients in the facility where you work may have seizures which may be due to a variety of causes. There are many different kinds of seizures. The most severe type is the grand mal seizure. For someone who has never witnessed this type of seizure, it can be a very frightening experience. In this lesson, we will discuss the various types of seizures and nursing actions you should take for the patient with seizures.

LESSON PLAN: 27

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-17

OUTLINE: (Key Points)

I. Two Major Types of Seizures
  A. Grand mal
    1. Characterized by severe violent involuntary contractions of the muscles
    2. Loss of consciousness
    3. Aura or warning usually preceeds
      a. Peculiar odor
      b. Bright lights flashing
    4. Followed by tonic phase or stiffening of the body
    5. Clonic phase or violent jerking movements of the body
    6. After the seizure, the patient is very tired and may sleep
  B. Petit Mal
    1. Characterized by staring into space
    2. Lasts approximately 30 seconds
    3. Patient's eyes are open but he/she is totally unaware of anything in the environment
    4. Appears to be daydreaming
  C. Other types of seizures
    1. Jacksonian
    2. Psychomotor
    3. Narcolepsy

II. Two Epileptic States

- A. Epileptic furor state
  - 1. Characterized by very irrational excited behavior
  - 2. May be unprovoked assault on property or people.
  - 3. Can be very dangerous
  - 4. No memory of the episode
- B. Epileptic equivalent state
  - 1. Instead of a seizure the person may run away or stop in middle of activity which he/she resumes after the state has ended

III. Symptoms of Deterioration Resulting from Seizures

- A. Irritability
- B. Slowness in thinking
- C. Confusion
- D. Poor memory

IV. Nursing Interventions for the Patient having a Seizure

- A. Most patients with seizures respond to medication.
  - 1. Dilantin
  - 2. Phenobarbital
  - 3. Myesoline
- B. Recognize each seizure patient's behavior pattern.
  - 1. It will be the same with each seizure.
  - 2. Safety measures can be taken.
    - a. Remove objects that can cause bodily injury.
    - b. Have the patient lie down in a safe place.
    - c. Place a padded tongue blade between the teeth - do not force it into his/her mouth.
- C. Do not move the patient during a seizure unless he/she is in a dangerous area.

D. Place padding under the patient's head during the seizure.

E. Do not restrain the patient.

V. Nursing Interventions Following the Seizure

A. Roll the patient onto his/her side to prevent choking on secretions.

B. Allow the patient to sleep.

C. Stay with the patient until he/she is alert.

VI. Observations to Report and Record

A. The patient's behavior at the beginning, during and following the seizure

B. Duration of the seizure

C. Any unusual incidents surrounding the seizure

D. Your nursing actions and the patient's response following the interactions

VII. Summary and Conclusion

A. Two major types of seizures

B. Two epileptic states

C. Symptoms of deterioration resulting from seizures

D. Nursing interventions for the patient having a seizure

E. Nursing interventions following the seizure

F. Observations to report and record

In this lesson, we have described two of the more common types of seizures. We have also discussed nursing interventions for the patient having a seizure as well as the observations to report and record.

LESSON PLAN: 27

COURSE TITLE: PSYCHIATRIC AIDE II

UNIT III : MENTAL HEALTH NURSING

INFORMATION TOPIC: III-17

INTERACTION ITEMS: (Review Items)

1. Describe a grand mal seizure.
2. Describe a petit mal seizure.
3. What is the nursing care for a patient having a seizure and following the seizure?
4. What observations about the seizure should be charted?

CLASSROOM, LABORATORY, SHOP OR OTHER ACTIVITIES:

Present a case study of a patient having a grand mal seizure. Ask the patient to describe in writing his/her actions and observations.

UNIT III

TEST II

True-False

In the space provided, place a "T" if the item is True or an "F" if the item is False.

_T_ 1. Learning to cope with frustration and directing aggression into appropriate activities serves to prevent assaultive behavior.

_T_ 2. Recognizing signs and symptoms of impending disruptive behavior serves as a preventive measure in the control of the assaultive patient.

_F_ 3. Communication is always appropriate when managing the assaultive patient.

_F_ 4. It is not necessary to limit the number of people caring for one patient with impaired brain function.

_T_ 5. The purpose of a remotivation group is for the members to become more aware of their own identity.

_T_ 6. It is very important for those caring for the patient with impaired brain function to remain calm and unhurried.

_F_ 7. A socially deviant person conforms to the norms established by society.

_T_ 8. A socially deviant patient is more likely to conform to the ward rules if consequences for breaking them are enforced quickly and consistently.

_F_ 9. One characteristic of the socially deviant person is their ability to make strong and lasting commitments to others.

_F_ 10. A more common term describing the patient who copes by withdrawing is depression.

_T_ 11. Schizophrenia is the most serious of all mental illnesses and the least understood.

_T_ 12. The emotional response of the patient who copes by withdrawing may be lacking or inappropriate.

_F_ 13. Establishing a trusting relationship with the patient who copes by withdrawing is very easy to do.

F 14. The patient who copes by withdrawing must not be allowed to express any anger.

F 15. When caring for the patient who copes by withdrawing, the Psychiatric Aide II should focus on the patient's diagnosis rather than behavior.

F 16. Loss of independence due to being hospitalized will have no effect on a patient's emotional well-being.

T 17. The patient who is elated can experience changes in their mood within a matter of hours.

T 18. Down's Syndrome, PKU, and Pick's Disease are conditions which can cause impaired brain function.

F 19. Acute brain syndromw is characterized by a gradual onset.

T 20. Reminiscence groups provide the elderly with an opportunity to review their lives.

F 21. Suicide occurs only in the lower socioeconomic groups.

T 22. The person who exhibits marked hostility, has no confidantes, and is very depressed is at higher risk for suicide than the person who successfully copes with stress and has a confidante.

Multiple Choice

Circle the correct response.

1. Which of the following are characteristic of the patient with an antisocial personality?

    a. Does not respond to medication

    b. Requires a structured environment

    c. Is very conscious of what peers think

    d. Develops shallow relationships with others

    e. None of the above

    [✓ f.] All of the above

2. The patient with an antisocial personality displays:

    a. good judgment.

    b. insight into his/her problem.

    c. consideration for others.

    [✓ d.] hostility.

3. The best approach for managing the antisocial patient is:

a. to allow free reign to do as he/she wishes.

[✓ b.] with firmness and consistency.

c. to assign him/her to supervise less capable patients.

d. to allow him/her to act as your assistant.

4. Which of the following are appropriate nursing interventions for preventing assaultive behavior?

a. Recognizing early signs of tension
b. Encouraging patients to control their feelings
c. Conveying a feeling of control which will create a sense of security
d. Developing an understanding of the patient's perceptions

[✓ 1.] All of the above

2. None of the above

3. b, c, & d

4. a, c, & d

5. Which of the following statements accurately describe delusions?

a. Control and/or rob thoughts
b. Usually auditory
c. Occassionally visual
d. Put thoughts in the patient's mind

1. All of the above

2. None of the above

[✓ 3.] a & d

4. b & c

6. An appropriate nursing intervention for the elated patient would be to:

a. place him/her in a small room with several other people.

b. encourage him/her to play chess.

c. encourage him/her to watch tv for at least an hour.

[✓ d.] take him/her on walks where there are few people and it is quiet.

7. Mr. Wiley has experienced several periods of depression for the past five years. Last evening, when the aide asked him how he was feeling, he responded, "This is the end. I'm not going to go on suffering this way any longer." It will be most important for the aide to:

   a. suggest to him that his family would be upset to hear him talk like this.

   b. tell him a few jokes to try to cheer him up.

   c. suggest to him that there are other people worse off than he is.

   [✓ d.] encourage him to express his feelings than later report what was said to the supervisor.

8. Mrs. Quince is an 80 year old patient who is not always sure of where she is and often thinks that nursing personnel are members of her family. One day when Miss Johnson, the psychiatric aide comes to take her outdoors, Mrs. Quince says in a bossy manner, "Molly, go chase the chickens out of my flower garden." Which of the responses would be best for the aide to make?

   a. "All right, grandma. After I get you outside, I'll take care of the chickens."

   b. "I'm not Molly and I don't know anything about your garden. Why do you say things like that?"

   [✓ c.] "I've come to take you outside, Mrs. Quince. While I help you with your slippers, tell me, what flowers did you have in your garden?"

   d. "Try to remember people's names. It's not very polite to forget them."

9. Communication with the elated patient should:

   a. involve lengthy explanations.

   b. include arguing with him/her if they are belligerent.

   [✓ c.] be short, simple, and direct.

   d. allow the patient's train of thought to wander without attempting to bring him/her back to the topic.

10. The elated patient exhibits the following behavior:

a. severe withdrawal.

[✓ b.] hyperactivity.

c. extreme suspiciousness.

d. antisocial behavior.

11. Which of the following is not a criteria for assessing the seriousness of the suicide plan?

a. Lethality of method

b. Availability of method

c. Detail of the plan

[✓ d.] Past history of coping with stress

12. Which of these statements about suicide is true?

a. Suicide is considered a cry for help.
b. Suicidal crisis is thought to be brought on by a real or perceived loss.
c. Suicide is highest among men over age 35 and 65.
d. Suicide rate among children is rising.

1. a, c, & d

2. a, b, & c

3. c & d

[✓ 4.] All of the above

13. This seizure is characterized by severe, violent contractions of all muscles of the body. It is:

a. Psychomotor.

[✓ b.] Grand mal.

c. Petit mal.

d. Narcolepsy.

14. When a patient has a grand mall seizure, you should:

a. force a tongue blade between the teeth regardless of possible injury to the patient.

b. carry the patient to a bed during the seizure.

c. make the patient get up and walk after the seizure.

[✓ d.] protect the patient during the seizure and allow him/her to rest afterwards.

15. Substance abuse is characterized by:

[✓ a.] psychological dependence.

b. withdrawal.

c. tolerance.

d. physiological dependence.

16. Substance abusers frequently:

[✓ a.] blame others for their problems.

b. have great insight into their problems.

c. respond well to treatment programs.

d. are very dependable and responsible.

17. Paranoia, hyperactivity, and aggression are symptoms of withdrawal from:

a. narcotics.

b. alcohol.

[✓ c.] stimulants.

d. depressants.

18. Dilated pupils, lethargy, yawning, and watery eyes are symptoms of withdrawal from:

[✓ a.] narcotics.

b. alcohol.

c. stimulants.

d. depressants.

19. Flushed face, blood shoot eyes, tremors, and visual hallucinations are symptoms of withdrawal from:

  a. narcotics.

  [✓ b.] alcohol.

  c. stimulants.

  d. depressants.

20. Limit setting involves:

  a. clearly defining the limits.
  b. establishing consequences for going beyond the limits.
  c. remaining firm and consistent.
  d. enforcing consequences quickly when the patient goes beyond the limits.

    [✓ 1.] All of the above

    2. a, c, & d

    3. b, c, & d

    4. None of the above

21. Defense mechanisms not usually used by substance abuser include:

  a. rationalization.

  b. denial.

  c. projection.

  [✓ d.] introjection.

22. The person who copes by withdrawing experiences:

  [✓ a.] severe anxiety.

  b. little or no anxiety.

  c. moderate anxiety.

  d. anxiety within normal limits.

23. The patient who is depressed will experience:

a. no changes in their sleep patterns.

[✓ b.] difficulty in falling asleep and early morning awakening.

c. alertness during the daytime.

d. no difficulty in getting up.

24. Which of the following is the drug of choice for the patient who is elated?

a. Tofranil

b. Thorazine

[✓ c.] Lithium

d. Cogentin

25. Patients suffering from chronic and/or acute Brain syndrome are generally more confused and disoriented during the:

a. daytime.

[✓ b.] night time.

c. late afternoon.

d. early evening.

26. When a potentially combative patient becomes verbally abusive, it is important for the Psychiatric Aide II to:

a. become verbally abusive.

b. become defensive.

c. criticize the patient for his/her actions.

[✓ d.] remain calm and in control.

27. The drug of choice for a seizure patient would be:

[✓ a.] Dilantin.

b. Tofranil.

c. Thorazine.

d. Lithium.

Completion

Put the following stages of grieving in their correct order. Place a "1" in the blank beside the first stage and number each stage as it occurs.

3 Bargaining

1 Denial

5 Acceptance

2 Anger

4 Despair

EVALUATION OF PSYCHIATRIC AIDE II COURSE
(To be completed by student)

1. Do you feel that the content of material presented to you in lecture was adequate? If not, how might this be changed? ____Yes ____No

2. Was there a portion of class you feel was not long enough? Comments: ____Yes ____No

3. Was there enough time allotted for discussion? Comments: ____Yes ____No

4. Did you feel that the time spent in clinical practice related to your classroom instruction? Comments: ____Yes ____No

5. Did you feel there was an adequate amount of time spent in clinical? Comments: ____Yes ____No

6. Return demonstrations in class prepared me for my clinical rotation. If no, explain... ____Yes ____No

7. Were the audio-visual aides used beneficial? (For example: films, handouts, flip charts, etc.) ____Yes ____No
Comments:

8. Were the exams easy to read and understand? ____Yes ____No
Comments:

9. Was there any part of the 3 week class you felt was unnecessary? ____Yes ____No
Comments:

10. What information do you feel was most beneficial to you in performing your job at this hospital?
Comments:

11. What changes would you suggest for future classes?
Comments:

EVALUATION OF INSTRUCTOR(S)

Directions: Check appropriate response.

	Yes	No
1. Promoted teacher/student discussion.	___	___
2. Found ways to help students answer their own questions.	___	___
3. Encouraged students to express themselves freely and openly.	___	___
4. Seemed enthusiastic about the subject matter.	___	___
5. Spoke with expressiveness and variety in tone of voice.	___	___
6. Demonstrated the importance and significance of the subject matter.	___	___
7. Made presentations which were dry and dull.	___	___
8. Made it clear how each topic fit into the course.	___	___
9. Utilized constructive criticism to help students to improve their performance.	___	___
10. Encouraged student comments even when they turned out to be incorrect or irrelevant.	___	___
11. Summarized material in a manner which aided retention.	___	___
12. Explained course material clearly and explanations were to the point.	___	___
13. Related course material to real life situations.	___	___
14. Introduced stimulating ideas about the subject.	___	___
15. Stimulated students to intellectual effort.	___	___

Comments: